

55214 JUN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PAL 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RED NO 5311

| | | | | | | | | | | | | | |
|--|---------|---|-------------------|---|---------------------|---|-------------------------|--------------------------------------|-----------|---------|----------|------|----------|
| 1. FOR STATE REGISTRAR | | DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | ESTIMATED | MONTH | DAY | YEAR | 2b. HOUR |
| | | Joseph Emerick Barnes | | | | | X | | | 5 | 25 | 1987 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | MONTH | DAY | YEAR | 2d. HOUR | | |
| Male | Black | Apr. 6, 1938 | 49 | | | 5/25/1987 | | | | | 12:45 | A M | |
| 7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | U.S.A. | | WIDOWED | | DIVORCED | | St. May's County | | MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Leonardtown | | St. Mary's Hospital | | Roofer | | Construction | | | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | | | | | | |
| Md. | | St. Mary's | Leonardtown | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | General Delivery | | 20650 | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| James Barnes | | Phileo Bennett | | No | | 220-34-4080 | | Mary Ernestine Barnes, same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | 12:15xx 5/25/1987 | | subject driver of auto/fixed object impact | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | roadway | | Rt. #5, Leonardtown, St. Mary's Co., Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | |
| Dennis F. Smyth, M.D. | | Assistant | | 5/25/87 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 5-30-87 | | Charles Memorial Gardens | | Leonardtown, St. Mary's, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| W. Clarke Mattingley | | Leonardtown, Md. | | JUN 1 1987 | | | | | | | | | |

07-B4
25M

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DHMH-17
(VR A15 ME (5))

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 5 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8715318
REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (LAST OR FIRST) FIRST MIDDLE LAST DORA LEE CARTER | | 2a. DATE OF DEATH MONTH DAY YEAR May 23, 1987 | | 2b. HOUR 2:58 P. | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR FEB. 10, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD. | |
| 10. CITY OR TOWN OF DEATH LEONARDTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY ST. MARY'S | | 13c. CITY OR TOWN LEXINGTON PK. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PARIS WILLIAMSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EBBIE MAY | | 13e. STREET ADDRESS / ZIP CODE 335 MIDWAY DRIVE 20653 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 401-01-2687 | | 17. INFORMANT ADDRESS 335 MIDWAY DRIVE MARY LEE DIAMOND, LEXINGTON PARK, MD. 20653 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable Cerebrovascular</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1980</u> , 19 <u>5-23-87</u> , to <u>5-23-87</u> , that (I) (we) lost saw the deceased alive on <u>5/23/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Wm. D. Boyd II, M.D.</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/25/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. D. Boyd II, M.D. | | 22e. ADDRESS Leonardtwn, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5/27/87 | | 23c. NAME OF CEMETERY OR CREMATORY THE FAMILY CEMETERY | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE RACON, PIKE, KENTUCKY | |
| 24. FUNERAL DIRECTOR NAME ADDRESS EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 1 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Rodman</u> | |

BP

NOTICE
TO THE PUBLIC
OF THE
CITY OF NEW YORK

NOTICE
TO THE PUBLIC
OF THE
CITY OF NEW YORK

02515

11/15/11

11/15/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked checked, it shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15317
REG. NO.

| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OZELLA NMI COOLEY | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 21, 1987 | | 2b. HOUR 1055 A | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 10, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. MONTHS DAYS HRS. MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD. | |
| 10. CITY OR TOWN OF DEATH LEONARDTOWN | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mid-wife | | 12b. KIND OF BUSINESS OR INDUSTRY Nursing |
| 13a. STATE Md. | 13b. COUNTY St. Mary's | 13c. CITY OR TOWN Lexington Park | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Wesley Cooley | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Cannon | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-18-3789 | | 17. INFORMANT ADDRESS Sylvia Copeland, Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonia + Renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) Acute Cerebrovascular accident + Grand Mal Seizures | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/20 , 19 85 , to 5/21 , 19 87 , that (I) (we) last saw the deceased alive on 5/21 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death. | | | | | |
| 22b. SIGNATURE DR. JAMES C. BOYD M.D. | | DEGREE | | 22c. DATE SIGNED 5/22/87 | |
| 22d. ATTENDING PHYSICIAN | | MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22e. ADDRESS LEONARDTOWN, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial | | 23b. DATE 5-25-87 | | 23c. NAME OF CEMETERY OR CREMATORY 1st. Baptist Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Lexington Pk. St. Mary's, MD | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley, Leonardtown, MD. | | 25a. DATE REC'D. BY REGISTRAR MAY 27 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

BP

RECEIVED
JAN 10 1964

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [illegible]

RE: [illegible]

[The body of the letter contains several paragraphs of extremely faint, illegible text. The text appears to be a standard memorandum format, but the specific details are not discernible.]

44-38861-1000



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8715321
REG. NO.

| | | | | | |
|---|--|--|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN. | |
| JOHN DOUGLAS CROSS, SR. | | May 28, 1987 | | 9:31 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR | 82 YRS. | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | U.S.A. | | St. Mary's County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Leonardtown | St. Mary's Hospital | Doctor | Dentistry | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | St. Mary's | Coltons Point | YES <input type="checkbox"/> NO <input type="checkbox"/> | General Delivery/20626 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. SOCIAL SECURITY NO. | | | |
| Harry Brodhead | Lillian M. Campbell | 213-38-3015 | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 17b. INFORMANT | 17c. ADDRESS | | | |
| No | John D. Cross Jr. | Box 18A, Locks Hill Rd., Mechanicsville/ | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Parkinsons Disease</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| - | - | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| <input type="checkbox"/> | HOUR A.M. MONTH DAY YEAR | | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> | | STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/27</u> 19 <u>87</u> , to <u>5/28</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/28</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED | | |
| <u>David Allen</u> | | | <u>5/29/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| David Allen, M.D. | Leonardtown, Md. 20650 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 6-1-87 | Cedar Hill Cemetery | Sutland, P.G. Md. | | |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| NAME ADDRESS | JUN 1 1987 | | <u>Julia Gordon-Randall</u> | | |
| W. Clarke Mattingley, Leonardtown, Md. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 1j, 1k, 1l, 1m, 1n, 1o, 1p, 1q, 1r, 1s, 1t, 1u, 1v, 1w, 1x, 1y, 1z, 2a, 2b, 2c, 2d, 2e, 2f, 2g, 2h, 2i, 2j, 2k, 2l, 2m, 2n, 2o, 2p, 2q, 2r, 2s, 2t, 2u, 2v, 2w, 2x, 2y, 2z, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 3i, 3j, 3k, 3l, 3m, 3n, 3o, 3p, 3q, 3r, 3s, 3t, 3u, 3v, 3w, 3x, 3y, 3z, 4a, 4b, 4c, 4d, 4e, 4f, 4g, 4h, 4i, 4j, 4k, 4l, 4m, 4n, 4o, 4p, 4q, 4r, 4s, 4t, 4u, 4v, 4w, 4x, 4y, 4z, 5a, 5b, 5c, 5d, 5e, 5f, 5g, 5h, 5i, 5j, 5k, 5l, 5m, 5n, 5o, 5p, 5q, 5r, 5s, 5t, 5u, 5v, 5w, 5x, 5y, 5z, 6a, 6b, 6c, 6d, 6e, 6f, 6g, 6h, 6i, 6j, 6k, 6l, 6m, 6n, 6o, 6p, 6q, 6r, 6s, 6t, 6u, 6v, 6w, 6x, 6y, 6z, 7a, 7b, 7c, 7d, 7e, 7f, 7g, 7h, 7i, 7j, 7k, 7l, 7m, 7n, 7o, 7p, 7q, 7r, 7s, 7t, 7u, 7v, 7w, 7x, 7y, 7z, 8a, 8b, 8c, 8d, 8e, 8f, 8g, 8h, 8i, 8j, 8k, 8l, 8m, 8n, 8o, 8p, 8q, 8r, 8s, 8t, 8u, 8v, 8w, 8x, 8y, 8z, 9a, 9b, 9c, 9d, 9e, 9f, 9g, 9h, 9i, 9j, 9k, 9l, 9m, 9n, 9o, 9p, 9q, 9r, 9s, 9t, 9u, 9v, 9w, 9x, 9y, 9z, 10a, 10b, 10c, 10d, 10e, 10f, 10g, 10h, 10i, 10j, 10k, 10l, 10m, 10n, 10o, 10p, 10q, 10r, 10s, 10t, 10u, 10v, 10w, 10x, 10y, 10z, 11a, 11b, 11c, 11d, 11e, 11f, 11g, 11h, 11i, 11j, 11k, 11l, 11m, 11n, 11o, 11p, 11q, 11r, 11s, 11t, 11u, 11v, 11w, 11x, 11y, 11z, 12a, 12b, 12c, 12d, 12e, 12f, 12g, 12h, 12i, 12j, 12k, 12l, 12m, 12n, 12o, 12p, 12q, 12r, 12s, 12t, 12u, 12v, 12w, 12x, 12y, 12z, 13a, 13b, 13c, 13d, 13e, 13f, 13g, 13h, 13i, 13j, 13k, 13l, 13m, 13n, 13o, 13p, 13q, 13r, 13s, 13t, 13u, 13v, 13w, 13x, 13y, 13z, 14a, 14b, 14c, 14d, 14e, 14f, 14g, 14h, 14i, 14j, 14k, 14l, 14m, 14n, 14o, 14p, 14q, 14r, 14s, 14t, 14u, 14v, 14w, 14x, 14y, 14z, 15a, 15b, 15c, 15d, 15e, 15f, 15g, 15h, 15i, 15j, 15k, 15l, 15m, 15n, 15o, 15p, 15q, 15r, 15s, 15t, 15u, 15v, 15w, 15x, 15y, 15z, 16a, 16b, 16c, 16d, 16e, 16f, 16g, 16h, 16i, 16j, 16k, 16l, 16m, 16n, 16o, 16p, 16q, 16r, 16s, 16t, 16u, 16v, 16w, 16x, 16y, 16z, 17a, 17b, 17c, 17d, 17e, 17f, 17g, 17h, 17i, 17j, 17k, 17l, 17m, 17n, 17o, 17p, 17q, 17r, 17s, 17t, 17u, 17v, 17w, 17x, 17y, 17z, 18a, 18b, 18c, 18d, 18e, 18f, 18g, 18h, 18i, 18j, 18k, 18l, 18m, 18n, 18o, 18p, 18q, 18r, 18s, 18t, 18u, 18v, 18w, 18x, 18y, 18z, 19a, 19b, 19c, 19d, 19e, 19f, 19g, 19h, 19i, 19j, 19k, 19l, 19m, 19n, 19o, 19p, 19q, 19r, 19s, 19t, 19u, 19v, 19w, 19x, 19y, 19z, 20a, 20b, 20c, 20d, 20e, 20f, 20g, 20h, 20i, 20j, 20k, 20l, 20m, 20n, 20o, 20p, 20q, 20r, 20s, 20t, 20u, 20v, 20w, 20x, 20y, 20z, 21a, 21b, 21c, 21d, 21e, 21f, 21g, 21h, 21i, 21j, 21k, 21l, 21m, 21n, 21o, 21p, 21q, 21r, 21s, 21t, 21u, 21v, 21w, 21x, 21y, 21z, 22a, 22b, 22c, 22d, 22e, 22f, 22g, 22h, 22i, 22j, 22k, 22l, 22m, 22n, 22o, 22p, 22q, 22r, 22s, 22t, 22u, 22v, 22w, 22x, 22y, 22z, 23a, 23b, 23c, 23d, 23e, 23f, 23g, 23h, 23i, 23j, 23k, 23l, 23m, 23n, 23o, 23p, 23q, 23r, 23s, 23t, 23u, 23v, 23w, 23x, 23y, 23z, 24a, 24b, 24c, 24d, 24e, 24f, 24g, 24h, 24i, 24j, 24k, 24l, 24m, 24n, 24o, 24p, 24q, 24r, 24s, 24t, 24u, 24v, 24w, 24x, 24y, 24z, 25a, 25b, 25c, 25d, 25e, 25f, 25g, 25h, 25i, 25j, 25k, 25l, 25m, 25n, 25o, 25p, 25q, 25r, 25s, 25t, 25u, 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41f, 41g, 41h, 41i, 41j, 41k, 41l, 41m, 41n, 41o, 41p, 41q, 41r, 41s, 41t, 41u, 41v, 41w, 41x, 41y, 41z, 42a, 42b, 42c, 42d, 42e, 42f, 42g, 42h, 42i, 42j, 42k, 42l, 42m, 42n, 42o, 42p, 42q, 42r, 42s, 42t, 42u, 42v, 42w, 42x, 42y, 42z, 43a, 43b, 43c, 43d, 43e, 43f, 43g, 43h, 43i, 43j, 43k, 43l, 43m, 43n, 43o, 43p, 43q, 43r, 43s, 43t, 43u, 43v, 43w, 43x, 43y, 43z, 44a, 44b, 44c, 44d, 44e, 44f, 44g, 44h, 44i, 44j, 44k, 44l, 44m, 44n, 44o, 44p, 44q, 44r, 44s, 44t, 44u, 44v, 44w, 44x, 44y, 44z, 45a, 45b, 45c, 45d, 45e, 45f, 45g, 45h, 45i, 45j, 45k, 45l, 45m, 45n, 45o, 45p, 45q, 45r, 45s, 45t, 45u, 45v, 45w, 45x, 45y, 45z, 46a, 46b, 46c, 46d, 46e, 46f, 46g, 46h, 46i, 46j, 46k, 46l, 46m, 46n, 46o, 46p, 46q, 46r, 46s, 46t, 46u, 46v, 46w, 46x, 46y, 46z, 47a, 47b, 47c, 47d, 47e, 47f, 47g, 47h, 47i, 47j, 47k, 47l, 47m, 47n, 47o, 47p, 47q, 47r, 47s, 47t, 47u, 47v, 47w, 47x, 47y, 47z, 48a, 48b, 48c, 48d, 48e, 48f, 48g, 48h, 48i, 48j, 48k, 48l, 48m, 48n, 48o, 48p, 48q, 48r, 48s, 48t, 48u, 48v, 48w, 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56p, 56q, 56r, 56s, 56t, 56u, 56v, 56w, 56x, 56y, 56z, 57a, 57b, 57c, 57d, 57e, 57f, 57g, 57h, 57i, 57j, 57k, 57l, 57m, 57n, 57o, 57p, 57q, 57r, 57s, 57t, 57u, 57v, 57w, 57x, 57y, 57z, 58a, 58b, 58c, 58d, 58e, 58f, 58g, 58h, 58i, 58j, 58k, 58l, 58m, 58n, 58o, 58p, 58q, 58r, 58s, 58t, 58u, 58v, 58w, 58x, 58y, 58z, 59a, 59b, 59c, 59d, 59e, 59f, 59g, 59h, 59i, 59j, 59k, 59l, 59m, 59n, 59o, 59p, 59q, 59r, 59s, 59t, 59u, 59v, 59w, 59x, 59y, 59z, 60a, 60b, 60c, 60d, 60e, 60f, 60g, 60h, 60i, 60j, 60k, 60l, 60m, 60n, 60o, 60p, 60q, 60r, 60s, 60t, 60u, 60v, 60w, 60x, 60y, 60z, 61a, 61b, 61c, 61d, 61e, 61f, 61g, 61h, 61i, 61j, 61k, 61l, 61m, 61n, 61o, 61p, 61q, 61r, 61s, 61t, 61u, 61v, 61w, 61x, 61y, 61z, 62a, 62b, 62c, 62d, 62e, 62f, 62g, 62h, 62i, 62j, 62k, 62l, 62m, 62n, 62o, 62p, 62q, 62r, 62s, 62t, 62u, 62v, 62w, 62x, 62y, 62z, 63a, 63b, 63c, 63d, 63e, 63f, 63g, 63h, 63i, 63j, 63k, 63l, 63m, 63n, 63o, 63p, 63q, 63r, 63s, 63t, 63u, 63v, 63w, 63x, 63y, 63z, 64a, 64b, 64c, 64d, 64e, 64f, 64g, 64h, 64i, 64j, 64k, 64l, 64m, 64n, 64o, 64p, 64q, 64r, 64s, 64t, 64u, 64v, 64w, 64x, 64y, 64z, 65a, 65b, 65c, 65d, 65e, 65f, 65g, 65h, 65i, 65j, 65k, 65l, 65m, 65n, 65o, 65p, 65q, 65r, 65s, 65t, 65u, 65v, 65w, 65x, 65y, 65z, 66a, 66b, 66c, 66d, 66e, 66f, 66g, 66h, 66i, 66j, 66k, 66l, 66m, 66n, 66o, 66p, 66q, 66r, 66s, 66t, 66u, 66v, 66w, 66x, 66y, 66z, 67a, 67b, 67c, 67d, 67e, 67f, 67g, 67h, 67i, 67j, 67k, 67l, 67m, 67n, 67o, 67p, 67q, 67r, 67s, 67t, 67u, 67v, 67w, 67x, 67y, 67z, 68a, 68b, 68c, 68d, 68e, 68f, 68g, 68h, 68i, 68j, 68k, 68l, 68m, 68n, 68o, 68p, 68q, 68r, 68s, 68t, 68u, 68v, 68w, 68x, 68y, 68z, 69a, 69b, 69c, 69d, 69e, 69f, 69g, 69h, 69i, 69j, 69k, 69l, 69m, 69n, 69o, 69p, 69q, 69r, 69s, 69t, 69u, 69v, 69w, 69x, 69y, 69z, 70a, 70b, 70c, 70d, 70e, 70f, 70g, 70h, 70i, 70j, 70k, 70l, 70m, 70n, 70o, 70p, 70q, 70r, 70s, 70t, 70u, 70v, 70w, 70x, 70y, 70z, 71a, 71b, 71c, 71d, 71e, 71f, 71g, 71h, 71i, 71j, 71k, 71l, 71m, 71n, 71o, 71p, 71q, 71r, 71s, 71t, 71u, 71v, 71w, 71x, 71y, 71z, 72a, 72b, 72c, 72d, 72e, 72f, 72g, 72h, 72i, 72j, 72k, 72l, 72m, 72n, 72o, 72p, 72q, 72r, 72s, 72t, 72u, 72v, 72w, 72x, 72y, 72z, 73a, 73b, 73c, 73d, 73e, 73f, 73g, 73h, 73i, 73j, 73k, 73l, 73m, 73n, 73o, 73p, 73q, 73r, 73s, 73t, 73u, 73v, 73w, 73x, 73y, 73z, 74a, 74b, 74c, 74d, 74e, 74f, 74g, 74h, 74i, 74j, 74k, 74l, 74m, 74n, 74o, 74p, 74q, 74r, 74s, 74t, 74u, 74v, 74w, 74x, 74y, 74z, 75a, 75b, 75c, 75d, 75e, 75f, 75g, 75h, 75i, 75j, 75k, 75l, 75m, 75n, 75o, 75p, 75q, 75r, 75s, 75t, 75u, 75v, 75w, 75x, 75y, 75z, 76a, 76b, 76c, 76d, 76e, 76f, 76g, 76h, 76i, 76j, 76k, 76l, 76m, 76n, 76o, 76p, 76q, 76r, 76s, 76t, 76u, 76v, 76w, 76x, 76y, 76z, 77a, 77b, 77c, 77d, 77e, 77f, 77g, 77h, 77i, 77j, 77k, 77l, 77m, 7



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|--|---------------------------------|--|
| 1- FOR STATE REGISTRAR | | 8 7 | | 1 5 3 2 2 | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE & PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | 2c. MIN. | |
| SUE VIRGINIA EVANS | | | | May 24, 1987 | | 5:15 | | A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | |
| FEMALE | | CAUCASIAN | | NOV. 10, 1915 | | 71 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | |
| WASHINGTON, D.C. | | U.S.A. | | | | St. Mary's | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Leonardtown | | St. Mary's Hospital | | HOMEMAKER | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | ST. MARY'S | | CHAPTICO | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | RT. #234, BOX 38 20621 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| LEO MURRAY | | CARRIE FILLIUS | | NO | | 578-20-7315 | | P.O. BOX 38 CHAPTICO, MD. 20621 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | (b) | | (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Cardio respiratory arrest | | Accelerated atherosclerosis | | Arteriosclerotic Heart Disease | | | | | |
| Conditions, if any, which gave rise to immediate cause 101, stating the underlying cause lost. | | (b) | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | Diabetes - Ruptured diverticulitis - Sepsis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 5.13.87 | | Ruptured diverticulitis | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. | | 5.23.87 | | 5.9.87 | | 5.24.87 | | 1987 | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| A. Samadi | | | | | | 5.25.87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | LEONARDTOWN, MARYLAND 20650 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| CREMATION | | 5/26/87 | | HUNTT CREMATORY | | WALDORF, CHARLES, MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| EDWARD N. BRINSFIELD, JR., | | LEONARDTOWN, MD. | | JUN 1 1987 | | Julia T. Tison-Randall | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

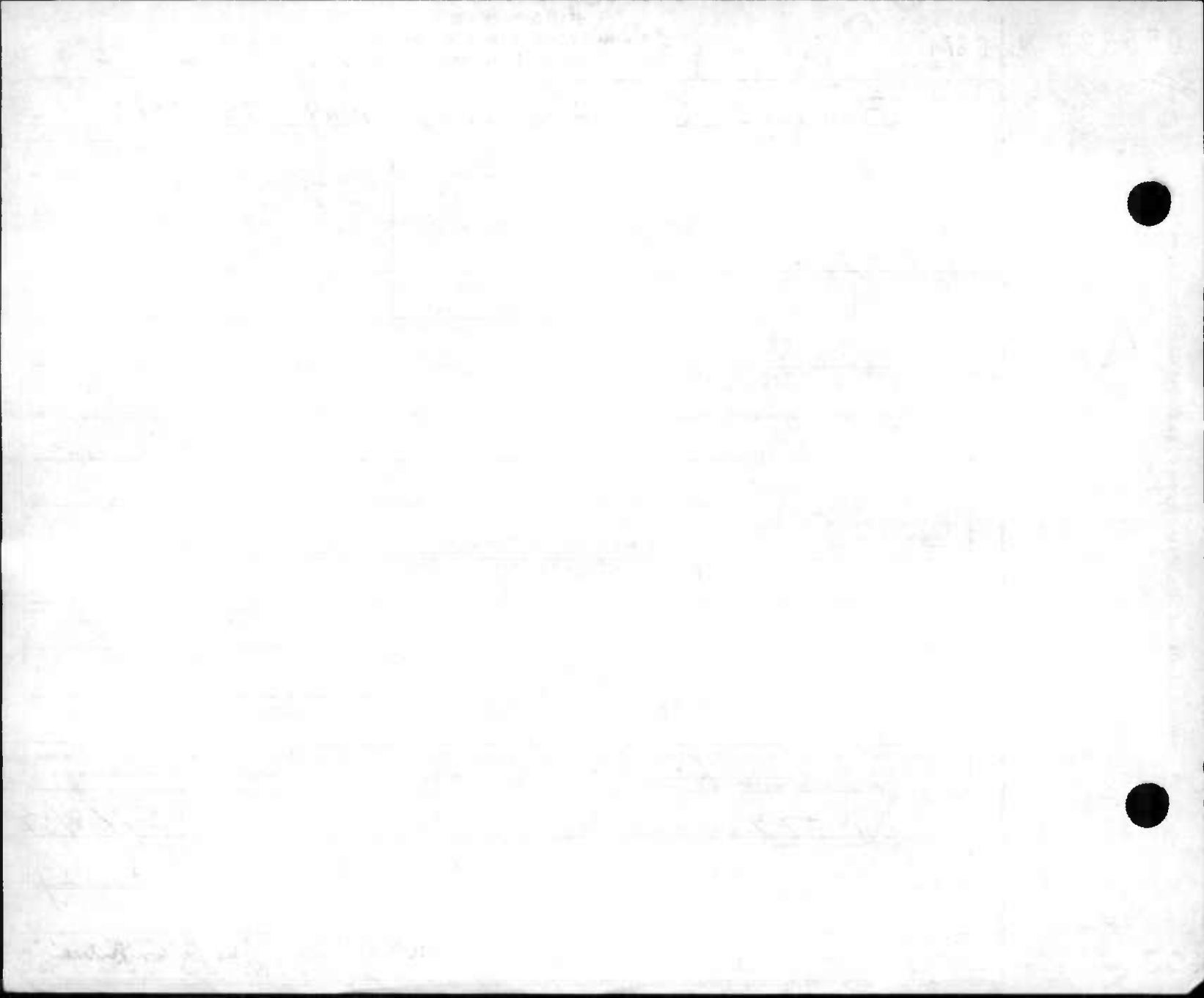
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15323
REG. NO.

| | | | | | |
|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BLANCHE C GOLDRING | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 28, 1987 | | 2b. HOUR M |
| 3 SEX Female | 4 RACE Black | 5 DATE OF BIRTH MONTH DAY YEAR Dec. 22, 1924 | 6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH /charles/ St. Marys MD | | |
| 10 CITY OR TOWN OF DEATH Charlotte Hall | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home - Oakes Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook | 12b. KIND OF BUSINESS OR INDUSTRY Restaraunt | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY St. Mary's | 13c. CITY OR TOWN Charlotte Hall | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST Joseph Samuel Goldring | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie B. Neal | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-38-1395 | 17 INFORMANT ADDRESS Mary Ellen Mason, Nat. Mobile Home, Lot 41 Box 67, Lexington Park, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection DUE TO, OR AS A CONSEQUENCE OF (b) metastatic cancer DUE TO, OR AS A CONSEQUENCE OF (c) Cancer breast left APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks 1 yr 18 mo | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): None | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 57 to May 87 , that (I) (we) lost saw the deceased alive on 5/11/87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If type (d) did not view the body after death. | | | | | |
| 22b. SIGNATURE D. Mossman One | | DEGREE MD | | 22c. DATE SIGNED 5/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DL MUSSMAN | | 22e. ADDRESS 173 Box 2 Mahanville Rd 2069 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | 23b. DATE 5-30-87 | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24 FUNERAL DIRECTOR NAME W. Clarke / Mawlingley / Leonardtown, Md. | | 25a. FILED BY REGISTRAR JUN 02 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Benson-Randall | |

BP

DHMH-16 25M
(VRA 15, 4) 1/79



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 87-15324 REG. NO. | | | | | |
|--|--|---|--|---|---|---|--|--|------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) ADELINE EMMA GRAY | | | | | 2a. DATE OF DEATH MONTH MAY DAY 19 YEAR 1987 | | | 2b. HOUR 11:15A | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH Mar. DAY 12 YEAR 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD. | | | | |
| 10. CITY OR TOWN OF DEATH LEONARDTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. STATE Md. | | 13b. COUNTY St. Mary's | | 13c. CITY OR TOWN Mechanicsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 20 Waterview Dr./20659 | | |
| 14. FATHER'S NAME FIRST Robert MIDDLE E. LAST Blume | | | | | 15. MOTHER'S MAIDEN NAME FIRST Dena MIDDLE LAST Haid | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 577-03-3238D | | 17. INFORMANT ADDRESS Charles Robert Gray, same as 13e. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute recurrent Coronary Artery DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION 5/19 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/19 , 19 85 , to 5/19 , 19 87 , that (I) (we) last saw the deceased alive on 5/19/87 , 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE DR. JAMES C. BOYD M.D. | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/20/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JAMES C. BOYD M.D. | | | | | 22e. ADDRESS LEONARDTOWN, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-22-87 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, P.G. Md. | | | | |
| 24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 25 1987 | | 25b. REGISTRAR'S SIGNATURE W. Clarke Mattingley | | | |

BP

SAINT JOHN'S, N.B.

NOVEMBER 1914

RECEIVED

NOVEMBER 1914

NOVEMBER 1914

NOVEMBER 1914

NOVEMBER 1914

NOVEMBER 1914

NOVEMBER 1914

NOVEMBER 1914

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15325
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|--------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DAVID T. HARPER | | | 2a. DATE OF DEATH MONTH DAY YEAR May 2, 1987 | | 2b. HOUR 3:00A _M | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 26, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Leonardtwn | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | | 12b. KIND OF BUSINESS OR INDUSTRY USF&G | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | 13b. COUNTY Calvert | | 13c. CITY OR TOWN St. Leonard | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE General Delivery, 20685 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Harper | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Hohenstein | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1917/1920 | | 17. INFORMANT ADDRESS Effie Jo Harper, Same as #13 A-E | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Bilateral, lower lobes 23 days</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Melanoma, Renal Failure</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION - | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I, this hospital) attended the deceased from <u>4/28</u> , 19 <u>87</u> , to <u>5/2</u> , 19 <u>87</u> , that (we) lost saw the deceased alive on <u>5/1</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>David C. Allen</u> | | | DEGREE <u>M.D.</u> | | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/2/87</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Allen, M.D. | | | | | 22e. ADDRESS Leonardtwn, Maryland 20650 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 5-4-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Fairfax, Virginia | | | | |
| 24. FUNERAL DIRECTOR NAME Donald V. Borgwardt | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julius Anderson-Randall</u> | | | | |
| Rt 264, Box 34B, Port Republic, Maryland 20676 | | | | | | | | | | | |

052512

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 are filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

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0251212
12/15/50

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(1)

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

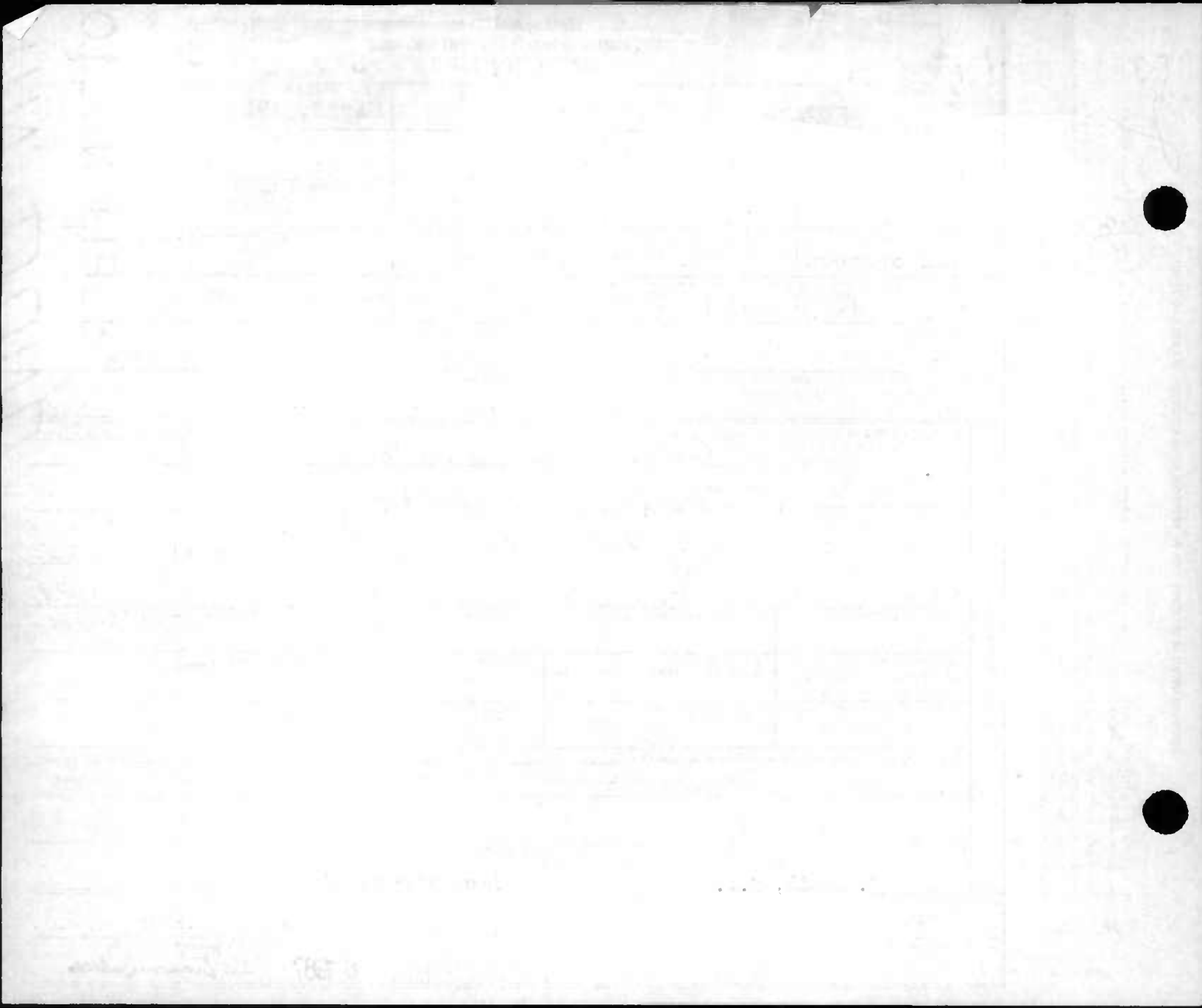
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15320
REG. NO

| | | | | | |
|---|---|--|---|--------------------------------|------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | May 5, 1987 | | 2:20A M | |
| EDWARD ROSS HENDERSON | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | White | May 17, 1900 | 86 YRS. | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | U.S.A. | | St. Mary's County MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Leonardtwn | St. Mary's Hospital | Civil Service | U.S. Navy | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | St. Mary's | Piney Point | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | General Delivery/20674 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | |
| Edward | Lula | | No | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | |
| 218-16-3001 | Mary Lumpkins, Leonardtown, Md. /20650 | | (a) Cardio Respiratory failure | | |
| | | | (b) Coronary Artery Disease | | |
| | | | (c) S/P Aorto-Coronary B. Pass Surgery | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| Chronic Obstructive Pulmonary Disease, Severe | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | | | | 22c. DATE SIGNED |
| | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| A. Patil, M.D. | Leonardtwn, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 5-7-87 | St. George Island Methodist Cemetery | St. George St. Mary's, Md. | | |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| W. Clarke Mattingley, Leonardtown, Md. 20650 | MAY 8 1987 | | Julia Tindon-Rodgers | | |



155215 JUN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15321

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1- STATE REGISTRAR | | FOR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. 15321 | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | |
| IDA | | ELIZABETH | | HOLLEY | | | | DATE KNOWN OF DEATH | |
| SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. DATE PRONOUNCED DEAD | |
| Female | | Black | | Oct. 5, 1920 | | 66 YRS. | | 5-24-1987 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Md. | | U.S.A. | | WIDOWED | | DIVORCED | | St. Mary's | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Patuxent River | | U.S. Naval Hospital | | House-wife | | Home | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | St. Mary's | | California | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 33 Coronado Drive/20619 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Robert | | Anna Rebecca White | | No | | 218-24-3290 | | 2009 First St. N.W. Washington, D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | |
| (b) | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> | | Inspection <input checked="" type="checkbox"/> | | Inquiry <input checked="" type="checkbox"/> | | and in my opinion | |
| death resulted from: | | Natural causes <input checked="" type="checkbox"/> | | Accident <input type="checkbox"/> | | Suicide <input type="checkbox"/> | | Homicide <input type="checkbox"/> | |
| | | | | | | | | Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | M.D. | | MEDICAL EXAMINER | | DATE SIGNED | |
| Wm. D. Boyd 11, M.D. | | Dpt | | | | | | 5/26/87 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Wm. D. Boyd 11, M.D. | | Leonardtwn, Md. 20650 | | Burial | | 5-30-87 | | St. Lukes Methodist | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 23d. LOCATION | | COUNTY STATE | |
| NAME | | ADDRESS | | JUN 1 1987 | | Scotland, St. Mary's, Md. | | | |
| W. Clarke Mattingley, Leonardtown, Md. | | | | | | | | | |

07 '84
25M

BP

DHMH - 17
(VR A15 ME (5))

WEST WOTTON FIELD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

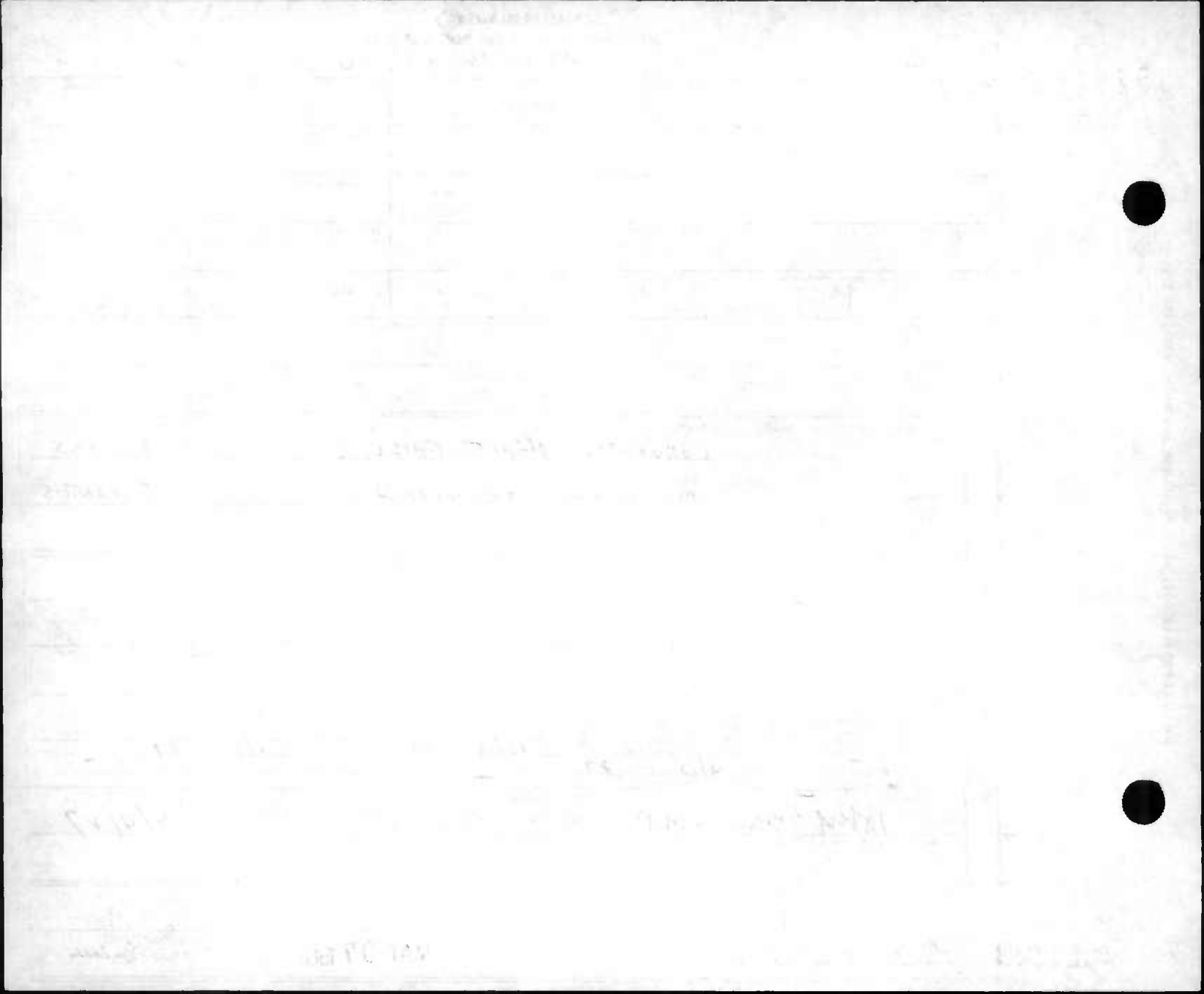
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / REG. NO. 15328

| | | | | | | | |
|--|--------|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) | | 2b. DATE OF DEATH | | 2c. HOUR | |
| RUFUS | | JOHN | | HOSTETLER | | MAY 3, 1987 | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 UNDER 1 YEAR | |
| Male | Cauc. | May 31, 1901 | | 85 YRS | | 8 UNDER 24 HRS | |
| 9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9b CITIZEN OF WHAT COUNTRY? | | 9c BALTIMORE CITY OR COUNTY OF DEATH | | 10 | |
| Mifflin, Pa. | | U.S.A. | | St. Mary's | | MD. | |
| 11 CITY OR TOWN OF DEATH | | 12 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 13a USUAL OCCUPATION | | 13b KIND OF BUSINESS OR INDUSTRY | |
| Mechanicsville | | st home | | Farmer | | Farming | |
| 14 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 15 INSIDE CITY LIMITS? | | 16 STREET ADDRESS | | 17 | |
| Md. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Box 176A Fairhaven Rd. | | 20659 | |
| 18 FATHER'S NAME | | 19 MOTHER'S MAIDEN NAME | | 20 | | 21 | |
| John | | Leah | | Zook | | 22 | |
| 23 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 24 SOCIAL SECURITY NO | | 25 INFORMANT | | 26 ADDRESS | |
| No | | | | John Hostetler | | Same as 13c | |
| 27 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | 28 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | 3 WEEKS | |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | 6 MONTHS | |
| (b) MYOCARDIAL INFARCTION | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 29a DATE OF OPERATION | | 29b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 30a AUTOPSY? | | 30b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 31a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 31b TIME OF INJURY | | 31c HOW INJURY OCCURRED | | 32 | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 33a INJURY OCCURRED | | 33b PLACE OF INJURY | | 33c LOCATION | | 34 | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN COUNTY STATE | |
| 35 I certify that (I) (this hospital) attended the deceased from 10/63 to 5/3, 1987, that (I) (we) last saw the deceased alive on 4/15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 36 SIGNATURE | | | | 37 DEGREE | | 38 DATE SIGNED | |
| Robert J. Bauer, M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 5/4/87 | |
| 39 PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 40 ADDRESS | | | |
| Robert J. Bauer, M.D. | | | | Mechanicsville, Md. 20659 | | | |
| 41a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 41b DATE | | 41c NAME OF CEMETERY OR CREMATORY | | 41d LOCATION | |
| Burial | | 5-5-87 | | Woodburn Hill | | Mechanicsville, St. Mary's, Md. | |
| 42 FUNERAL DIRECTOR | | | | 43 DATE REC'D BY REGISTRAR | | 44 REGISTRAR'S SIGNATURE | |
| W. Clarke Mattingley, Leonardtown, Md. | | | | MAY 07 1987 | | Julia Gordon-Randall | |



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

 87 15329
 REG. NO.

| | | | | | |
|--|---|--|--------------------------------------|--|--|
| 1- FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | 2b. HOUR | |
| VERA MARY KAPPLER | | May 30, 1987 | | 9:30P | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR | 68 | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Washington, D.C. | U.S.A. | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | St. Mary's County | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Leonardtwn | St. Mary's Hospital | Housewife | | Home | |
| 13a. STATE | | 13b. CITY OR TOWN | 13c. STREET ADDRESS / ZIP CODE | | |
| Md. | | St. Mary's Coltons Point | General Delivery, /20626 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| UNKNOWN | | Elsie Renschke | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 214-52-4679 | | William G. Kappler, same as 13c. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Lung</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/11 1987 to 5/30 1987, that (I) (we) lost the deceased on 5/30 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <i>Youngsik Moon</i> | | | | 5/31/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Youngsik Moon, M.D. | | Hollywood, Md, 20636 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 6-2-87 | | Fort Lincoln | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D BY REGISTRAR | | | |
| Brentwood, P.G., MD | | JUN 3 1987 | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D BY REGISTRAR | | | |
| W. Clarke Mattingley, Leonardtown, MD. | | JUN 3 1987 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

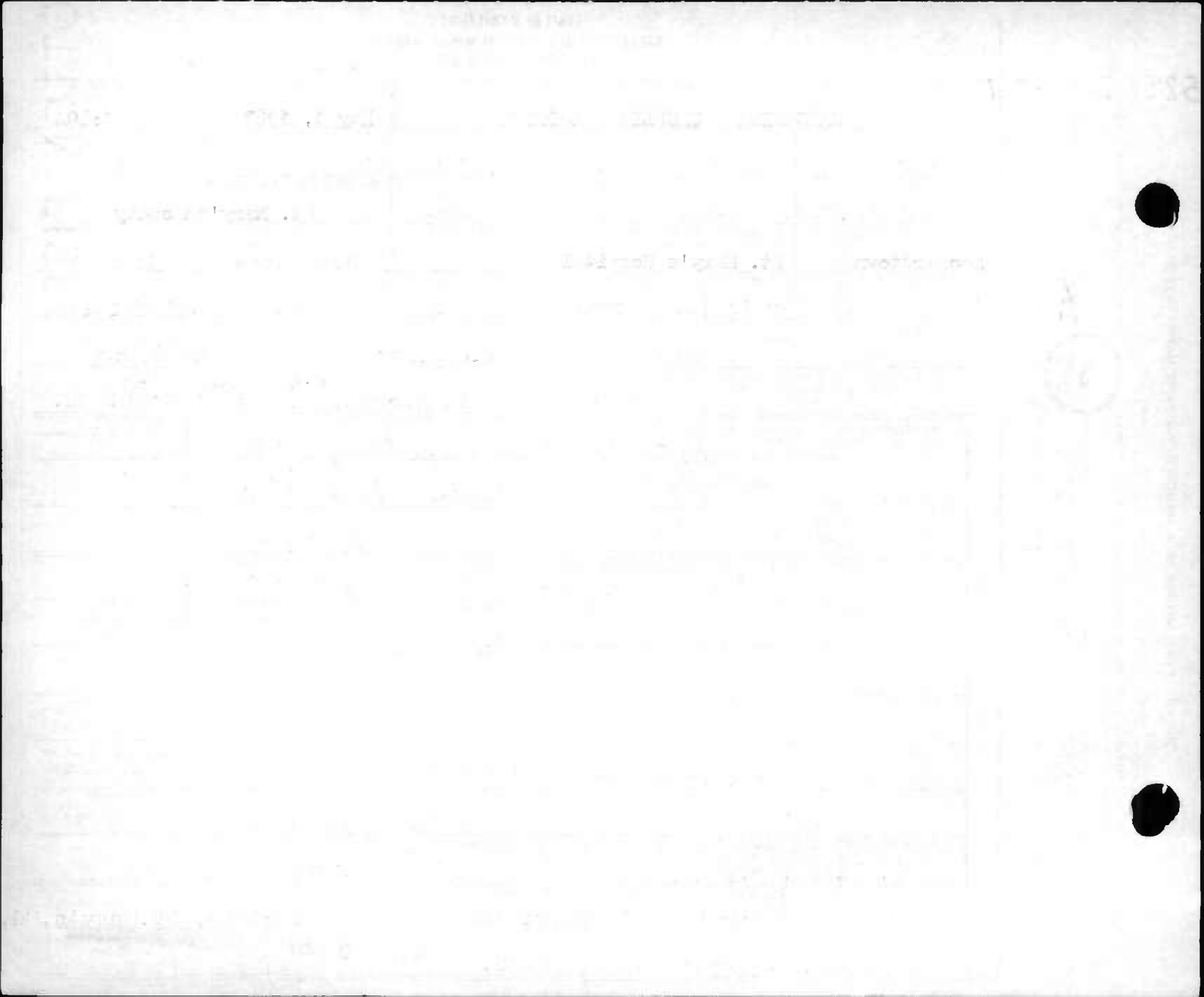
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the attending physician must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|-----------------------------------|--|--------------------------------|--|---|--|--------------------------------------|--|---------------------------------|--|------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BALTIMORE CITY OR COUNTY OF DEATH | | 8. DATE OF DEATH MONTH DAY YEAR | | 9. HOUR | |
| | | MARGARITA CECELIA KNITTER | | Female | | White | | April 27, 1909 | | 78 YRS. | | St. Mary's County MD. | | May 1, 1987 | | 1:40A M | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE | | 13b. INSIDE CITY LIMITS? | | 13c. CITY OR TOWN | | 13d. COUNTY | | 13e. STATE | |
| Leonardtwn | | St. Mary's Hospital | | Housewife | | Home | | 163 Woodlawn Drive/20619 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | California | | St. Mary's | | Md. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17a. ADDRESS | | 17b. CITY OR TOWN | | 17c. COUNTY | | 17d. STATE | |
| Felipe | | Katherine Sullivan | | No | | 216-42-8016 | | Bettie Hughes | | 330 Yorktown Rd. | | Lexington Park | | Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) <u>Chronic Obstructive Pulmonary Disease</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) <u>Bilateral Pleural Effusions</u> | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | | | | | | | |
| 20a. AUTOPSY? | | | | | | | | | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | | | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | | | |
| 22c. DATE SIGNED | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME | | | | | | | | | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | | | | | | | | | |
| A. Patil, m.d. Leonardtown, Md. 20650 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | | | | | | | | |
| 23b. DATE | | | | | | | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | | | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| Burial 5-4-87 Ebenezer Cemetery Great Mills, St. Mary's, Md. | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | | | | | | | | | | |
| W. Clarke Mattingley, Leonardtown, Md. | | | | | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | |
| MAY 5 1987 | | | | | | | | | | | | | | | | | |

BP



054572 MAY 27 1987

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

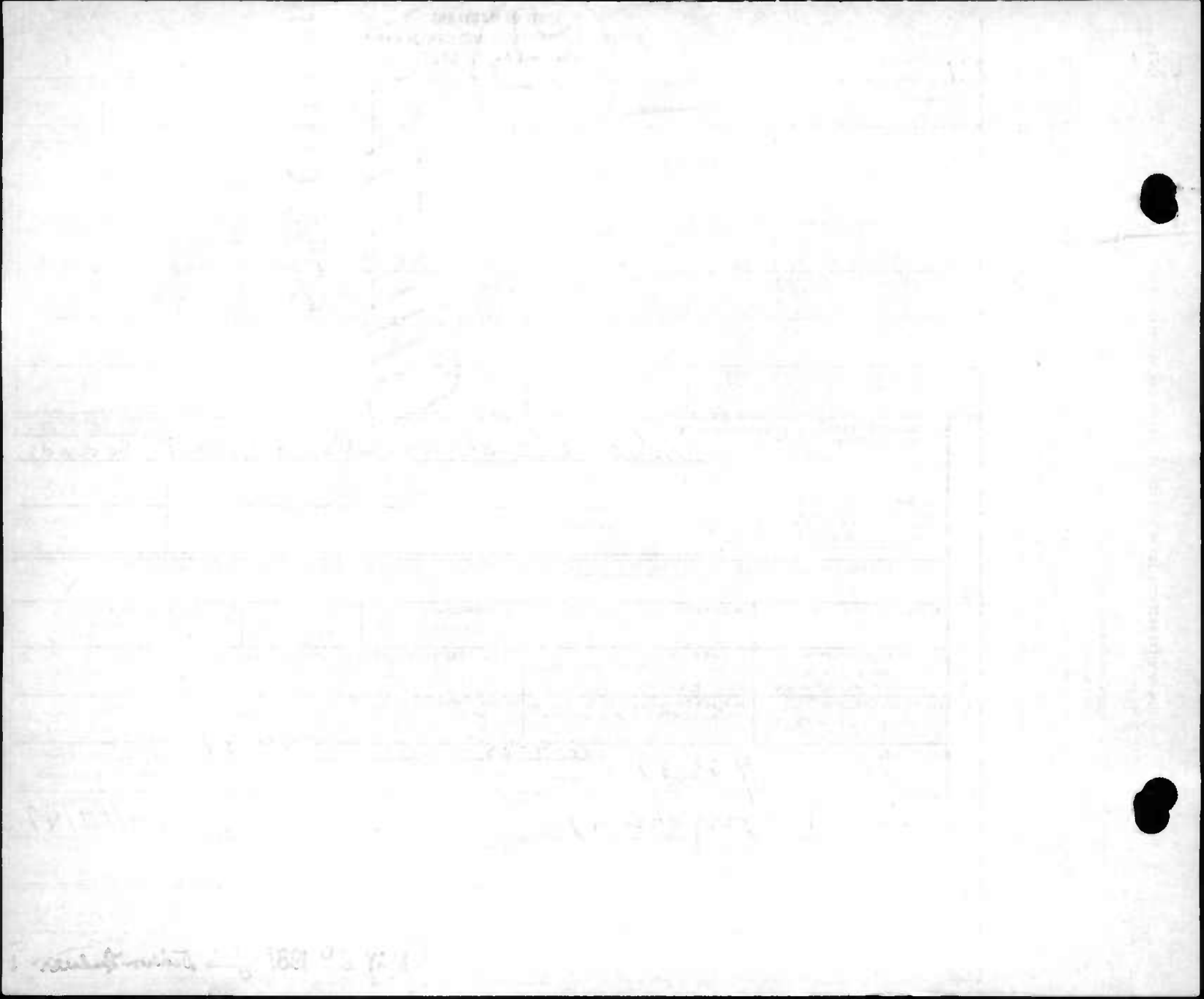
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15331

| | | | | | | | |
|--|--|---|---|---|-----------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET ELEANOR LETICH | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 18, 1987 | | 2b. HOUR 7:15 P.M. | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR NOV. 3, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH DAKOTA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD. | |
| 10. CITY OR TOWN OF DEATH LEXINGTON PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 463 TOWN CREEK DRIVE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOL TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS | |
| 13a. STATE MARYLAND | | 13b. COUNTY ST. MARY'S | | 13c. CITY OR TOWN LEXINGTON PARK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 463 TOWN CREEK DRIVE 20653 | | 14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL NEVILLE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN CHAPMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 470-40-4860 | | 17. INFORMANT MARGARET JEAN KLINE | | ADDRESS 463 TOWN CREEK DRIVE LEXINGTON PARK, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-9-85</u> , 19____, to <u>5-19-87</u> , 19____, that (I) (we) lost saw the deceased alive on <u>5-23-87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death. | | | | | | | |
| 22b. SIGNATURE <u>William D. Boyd</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/19/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. BOYD, 11 | | | | 22e. ADDRESS JEFFERSON STREET, LEONARDTOWN, MARYLAND 20650 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 5-19-87 | | 23c. NAME OF CEMETERY OR CREMATORY HUNTT CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE WALDORF CHARLES MARYLAND | |
| 24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR. | | | | ADDRESS LEONARDTOWN, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | | |



5467 JUN -4

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 15332 |
|--|-------------------------|---|---|---|-----------------------------|---|-------------------|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE GERTRUDE MADDOX | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> MONTH DAY YEAR MAY 30 1987 1b. HOUR 10:38 M |
| 3 SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 18, 1909 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 77 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 | 2d. HOUR M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD | | | | |
| 10. CITY OR TOWN OF DEATH Leonardtwn | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital | | | | 17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 17b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY St. Mary's | | 13c. CITY OR TOWN Piney Point | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS P.O. Box 112/20674 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John H. Thomas | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie B. White | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 578-16-2736 | | 17. INFORMANT ADDRESS Richard L. Maddox, same as 13e | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Death - Prob. Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Ischemic Heart Disease (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE David C. Allen | | | | TITLE (SPECIFY) M.D. | | | | DATE SIGNED 6/1/87 | | |
| EXAMINER'S NAME (TYPE OR PRINT) David C. Allen, M.D. | | | | ADDRESS Leonardtwn, Md. 20650 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6-4-87 | | 23c. NAME OF CEMETERY OR CREMATORY St. John's Episcopal | | 23d. LOCATION CITY OR TOWN COUNTY STATE Broad Creek, P.G., MD. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley, Leonardtown, Md. 20650 | | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | |

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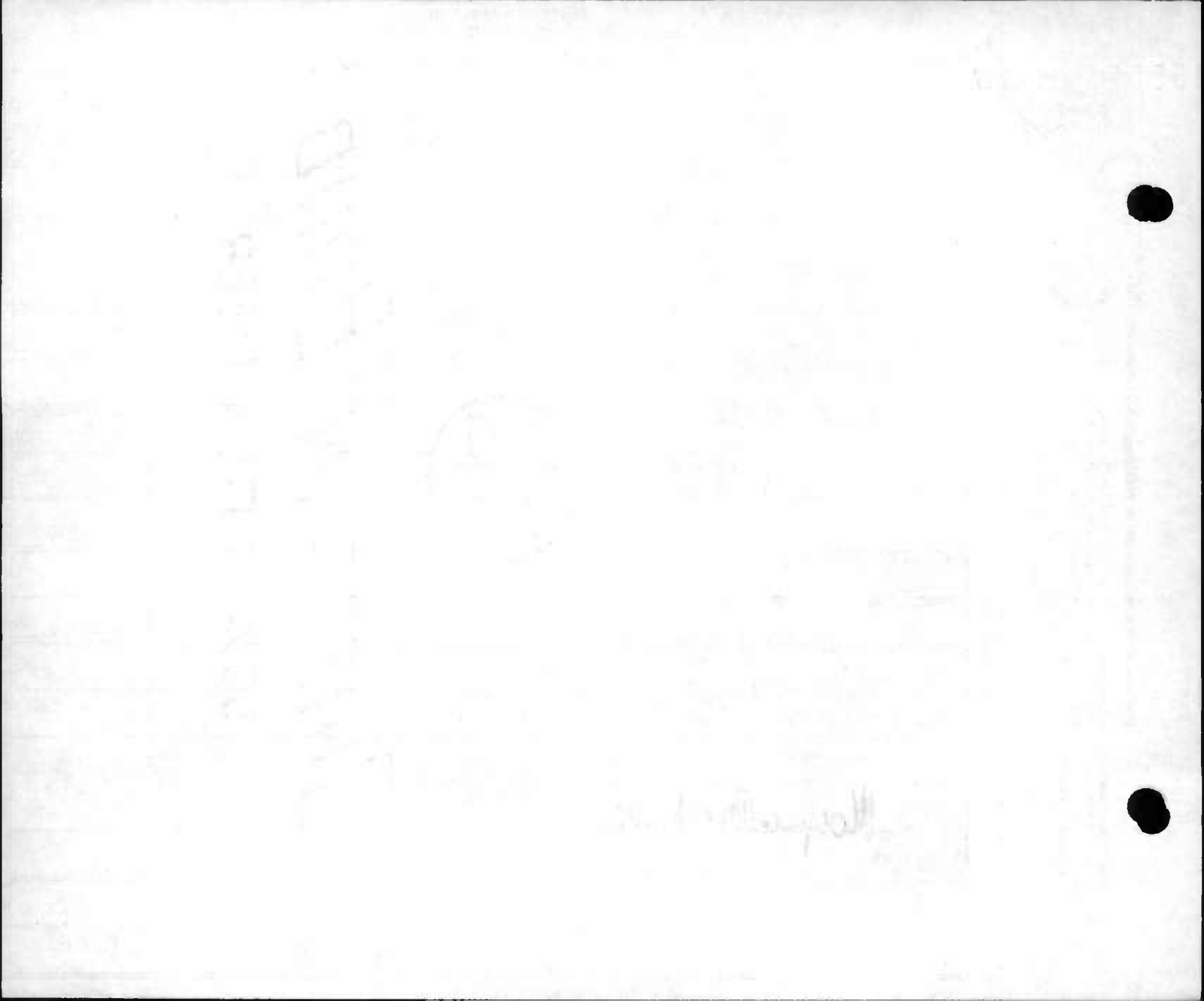
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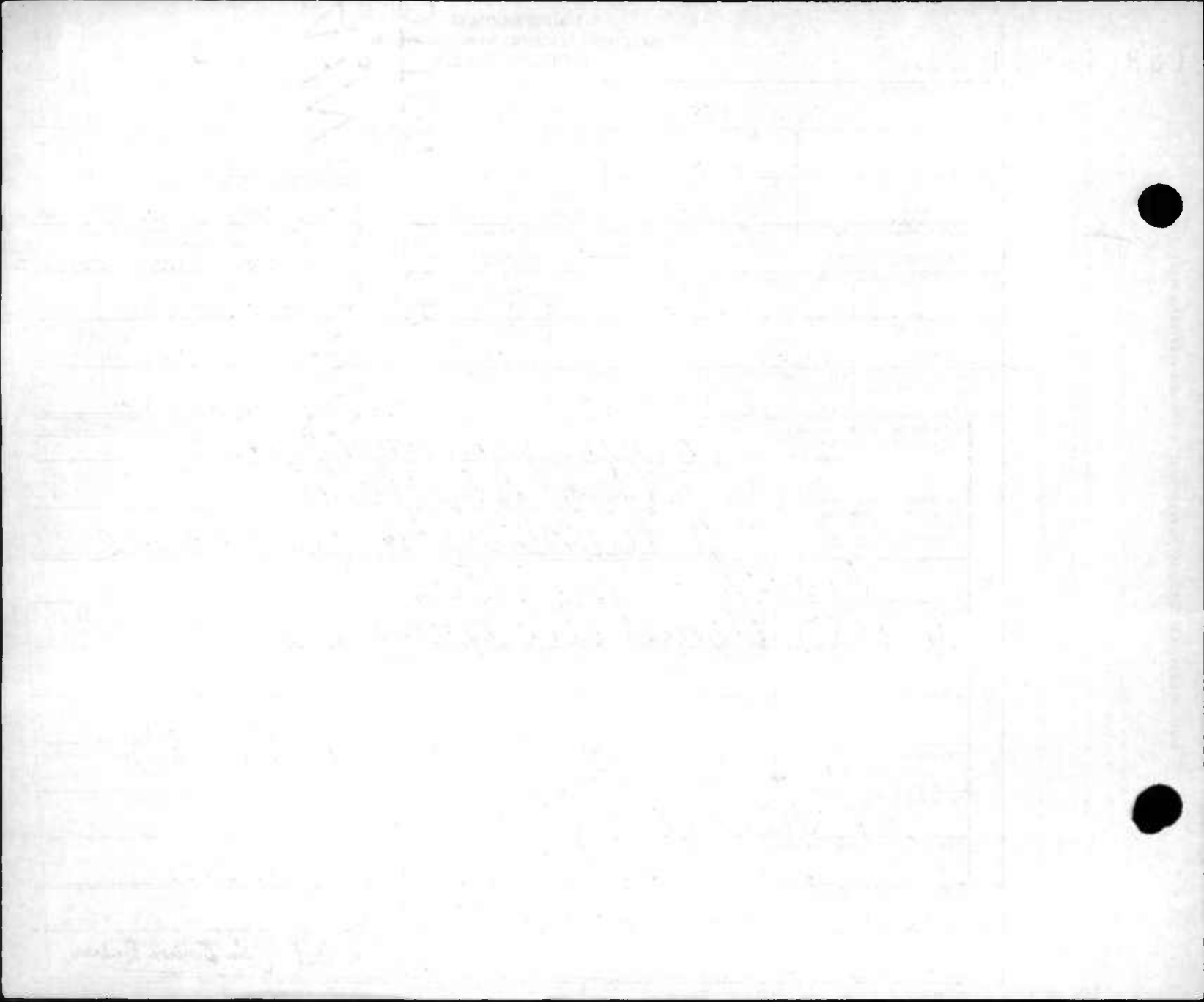
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, a cause of injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR 1:40 A | |
| ALOYSIUS | | DESALES | | MATTINGLY | | | | May 5, 1987 | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 31, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Leonardtwn | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | | | | | |
| 13a. STATE Md. | | 13b. COUNTY St. Mary's | | 13c. CITY OR TOWN Valley Lee | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE P.O. Box 52, / 20692 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Allen Mattingly | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Estelle Bailey | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 1943-46 | | 17. INFORMANT 577-26-3366 | | 17. ADDRESS Anna R. Mattingly, same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Abnormal fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION 4-30-87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED closure of colostomy | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4:30 1987 to 5:5 1987 that (I) (we) last saw the deceased alive on 4:30 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sew the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE A. Samadi MD | | 22c. DATE SIGNED | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Samadi, M.D. | | 22e. ADDRESS Leonardtwn, Md, 20650 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-8-87 | | 23c. NAME OF CEMETERY OR CREMATORY St. George Catholic Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Valley Lee, St. Mary's, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME W. Clarke Mattingley | | ADDRESS Leonardtwn, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 8 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall | | | | | |



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **15335**

| | | | | | | | | | | | | | | | | | |
|---|-----------|--|--|--|--|--------------------------------------|--|--|--|--------------------------|--|---|--|---|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Gomer Lewis McCroskey | | | | | | | | <input checked="" type="checkbox"/> EST. <input type="checkbox"/> MATED | | 5 | | 21 | | 1987 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| MALE | CAUCASIAN | JUNE 22, 1913 | | 73 YRS. | | | | | | 5 | | 21 | | 1987 | | 6:15A M | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| PENNSYLVANIA | | U.S.A. | | | | St. Mary's County, MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Leonardtwn | | St. Mary's Hospital | | ENGINEER | | CIVIL SERVICE | | | | | | | | | | | |
| 13a. STATE | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MARYLAND | | | | | | | | ST. MARY'S | | CALIFORNIA | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | RT # 2, BOX 309 | | 20619 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | |
| SAMUEL McCroskey | | | | EVA COOK | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| YES WW 11 | | | | 177-01-2974 | | | | KATHRYN E. McCROSKEY CALIFORNIA, MD. RT. # 2, BOX 309 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> 8/20 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5 XXX 5 21 19 87 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/tractor trailer impact | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 235 nr. Rt.6, Oakville, St. Mary's, MD. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED | | | | | |
| | | | | | | | | | | | | 5/21/87 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | |
| William M. Zane, M.D. | | | | 111 Penn St. | | | | Balto.MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| CREMATION | | | | 5-22-87 | | | | HUNTT CREMATORY | | | | WALDORF CHARLES MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| EDWARD N. BRINSFIELD, JR. LEONARDTOWN, MD. | | | | | | | | MAY 20 1987 | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1000. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



054516 MAY 25

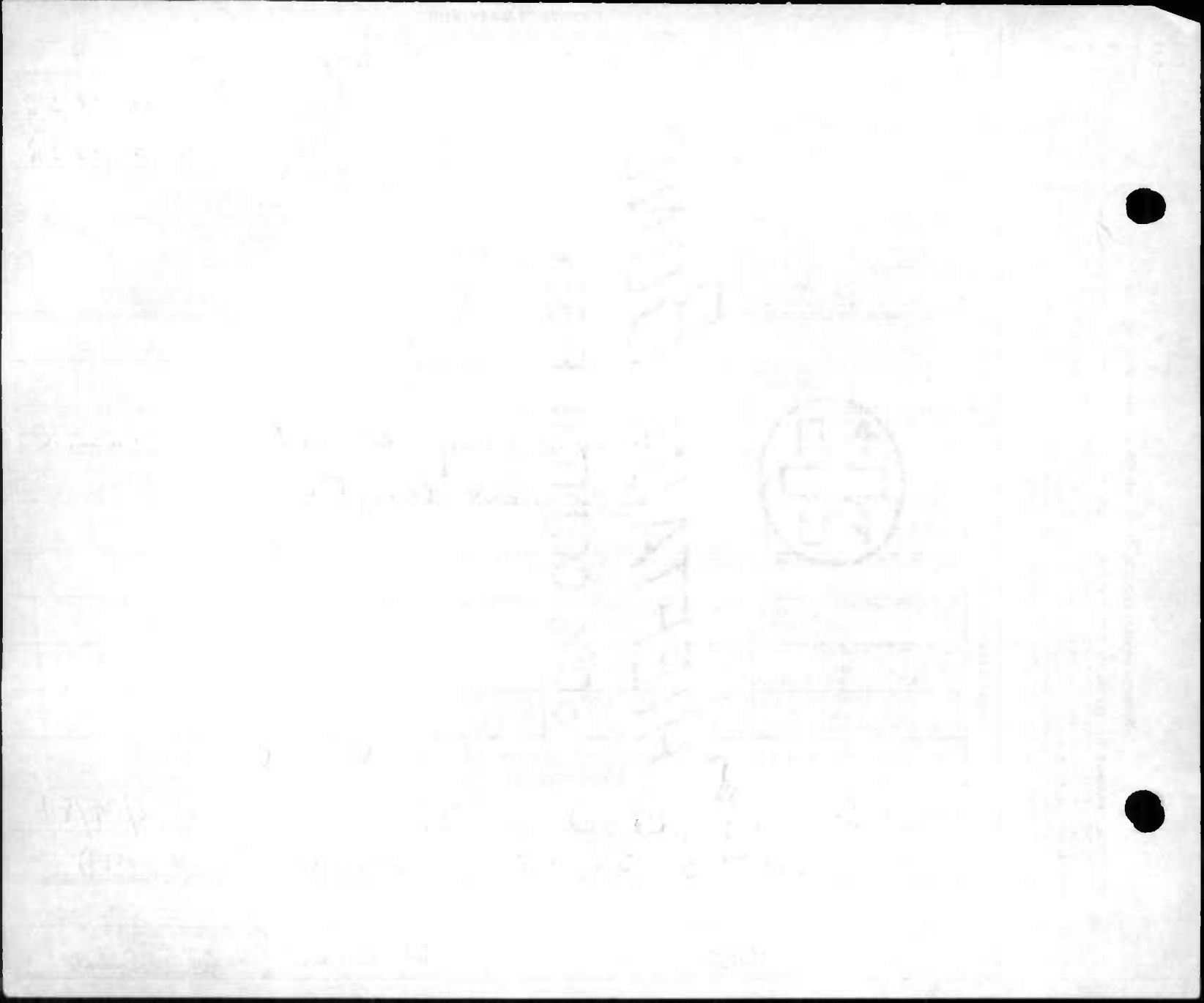
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15330

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|--|--------------------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2c. DATE ESTIMATED | | | | | | | | | | 2d. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MALISSA FLOYD MOORE | | | | | | | | | | 5 18 87 | | | | | | | | | | 3 15 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (IN YEARS) | | | | | | | | | | IF UNDER 1 YR. | | | | | | | | | | IF UNDER 24 HRS. | | | | | | | | | | 7c. DATE PRONOUNCED DEAD | | | | | | | | | | 7d. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Female | | | | | | | | | | Black | | | | | | | | | | Jan. 7, 1913 | | | | | | | | | | 74 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED | | | | | | | | | | NEVER MARRIED | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| North Carolina | | | | | | | | | | U.S.A. | | | | | | | | | | WIDOWED | | | | | | | | | | DIVORCED | | | | | | | | | | St. Mary's | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patuxent River | | | | | | | | | | Naval Air Station Hospital | | | | | | | | | | Housewife | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | St. Mary's | | | | | | | | | | Lexington Park | | | | | | | | | | NO | | | | | | | | | | Rt. 3 Box 81 20653 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Harkless | | | | | | | | | | Floyd | | | | | | | | | | Phedonia | | | | | | | | | | Tetterton | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | 237-14-2260 | | | | | | | | | | Thomas Moore | | | | | | | | | | Same as 13e | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Respiratory Arrest | | | | | | | | | | Immed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | Seizure disorder | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | P.M. 19 | | | | | | | | | | ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK | | | | | | | | | | 21e. PLACE OF INJURY | | | | | | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOT WHILE AT WORK | | | | | | | | | | STREET, FACTORY, FARM, ETC.) | | | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | | | | | | | | Autopsy Inspection Inquiry and in my opinion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Natural causes Accident Suicide Homicide Undetermined manner | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wm D. Boyd | | | | | | | | | | DPT | | | | | | | | | | 5/19/87 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wm D. Boyd | | | | | | | | | | Leonardtown, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 5/23/87 | | | | | | | | | | First Baptist Cemetery | | | | | | | | | | Hermansville St. Mary's | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| W. Clarke Mattingley | | | | | | | | | | MAY 25 1987 | | | | | | | | | | Julia Gordon | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



055481 JUN - 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

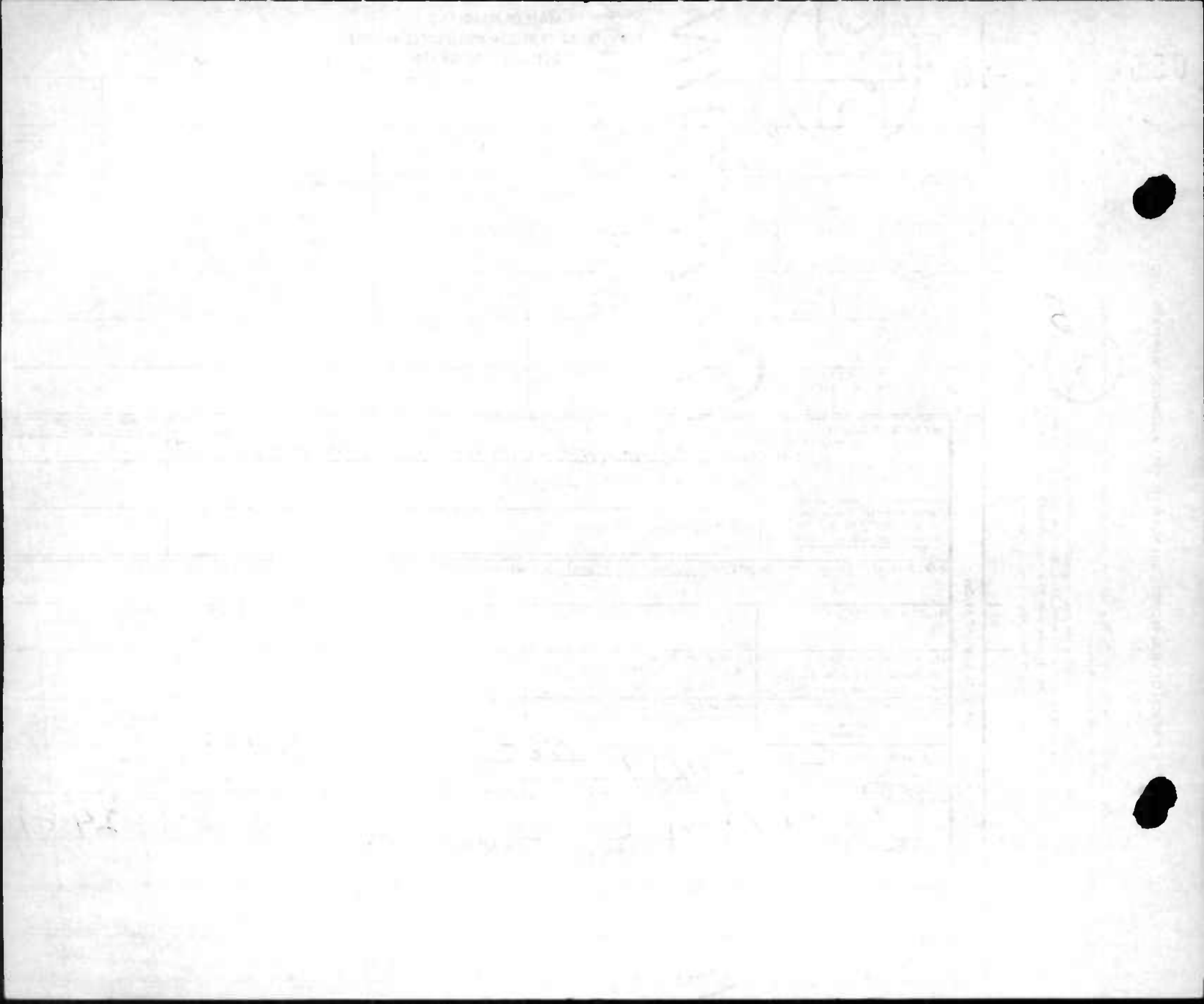
15337

| | | | | | | | | | | | |
|---|--|---|---|---|---------------------|---|--|--|-----------------------------------|-----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NANNIE LILLIAN MOORE | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 24, 1987 | | 2b. HOUR 5:10 am | | | | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 11, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD | | | | | |
| 10. CITY OR TOWN OF DEATH LEXINGTON PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMBER HOUSE NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | 13b. COUNTY ST. MARY'S | | 13c. CITY OR TOWN LEONARDTOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS RT. #244, BOX 452 20650 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM IRVING | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN STOKES | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 230-01-8213 | | 17. INFORMANT ADDRESS CHARLES LINTON, CHESTERFIELD, VIRGINIA | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1985 to 5/24/87, 1987, that (I) (we) last saw the deceased alive on 5/24/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>William D. Boyd, II</i> | | | | DEGREE | | | | 22c. DATE SIGNED 5/24/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. BOYD, II, M.D. | | | | 22e. ADDRESS 17 JEFFERSON ST., LEONARDTOWN, MD. 20650 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY BLANDFORD | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE PETERSBURG, NONE, VIRGINIA | | | |
| 24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1987 | | | | 25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Rodgers</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

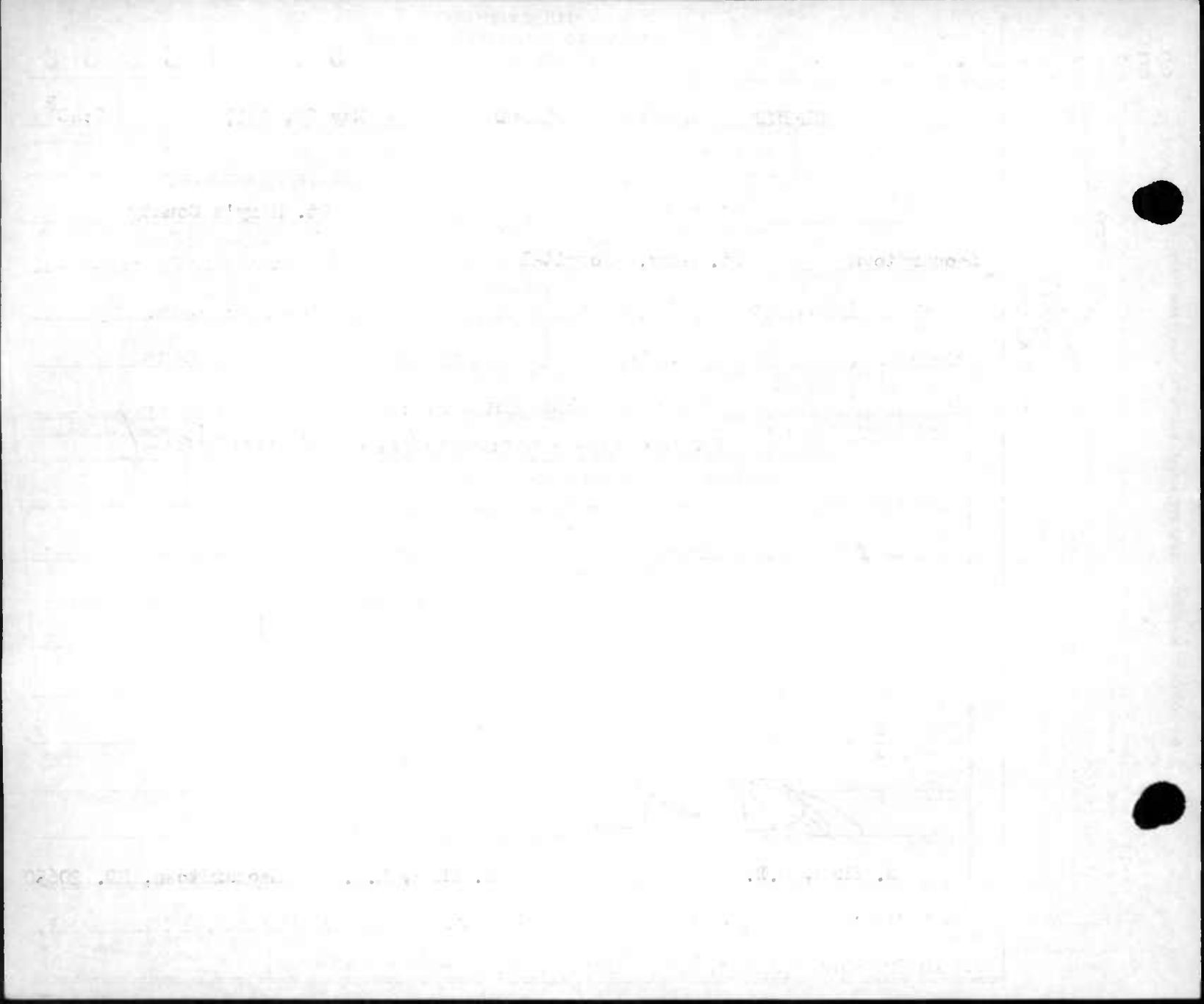
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical officer of the hospital or attending physician should be notified of the event.

DHMH - 16 60M 7/84
(VRA 15, 4)

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | |
| 1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLADYS GENEVA PENROD | | | | | | 2a DATE OF DEATH MONTH DAY YEAR May 25, 1987 | | 2b HOUR 2:40 ^P M | |
| 3. SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR NOV. 26, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD. | | | |
| 10 CITY OR TOWN OF DEATH Leonardtoun | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse -Nursing | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY St. Mary's | | 13c. CITY OR TOWN Hollywood | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 33 Pinto Drive/20636 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Butler | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Long | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b SOCIAL SECURITY NO. 218-40-0835 | | 17. INFORMANT ADDRESS Paul T. Penrod same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) _____ the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE | | | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. Shah, M.D. | | | | | | 22e. ADDRESS N. Shah, M.D. Leonardtown, MD. 20650 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 5-27-87 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley, Leonardtown, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 1 1987 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

BP



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|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| LORETTA | | EDITH | | DAVIS | | PERKINS | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 9. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Female | | White | | Feb. 17, 1904 | | 83 YRS. | | MONTHS | | DAYS | | HOURS | | MIN | | 5 | | 19 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MONTH | | DAY | | YEAR | |
| Md. | | U.S.A. | | MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | St. Mary's | | MONTH | | DAY | | YEAR | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS | | 13a. STREET ADDRESS | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 13f. INSIDE CITY LIMITS? | |
| Compton | | at home | | Clerk | | Laundry & Dry Cleaner | | Rt. 2, Box 39-G/20650 | | YES | | NO | | YES | | NO | | YES | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17. ADDRESS | | 17. ADDRESS | | 17. ADDRESS | | 17. ADDRESS | | 17. ADDRESS | |
| Albert | | Mary | | No | | 578-10-1097 | | Samuel Francis Perkins | | 111, same | | 111, same | | 111, same | | 111, same | | 111, same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I DEATH WAS CAUSED BY: | | PART I DEATH WAS CAUSED BY: | | PART I DEATH WAS CAUSED BY: | | PART I DEATH WAS CAUSED BY: | | PART I DEATH WAS CAUSED BY: | | PART I DEATH WAS CAUSED BY: | | PART I DEATH WAS CAUSED BY: | | PART I DEATH WAS CAUSED BY: | | PART I DEATH WAS CAUSED BY: | | PART I DEATH WAS CAUSED BY: | |
| IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | |
| DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 19c. DATE OF OPERATION | | 19d. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 19e. DATE OF OPERATION | | 19f. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 19g. DATE OF OPERATION | | 19h. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 19i. DATE OF OPERATION | | 19j. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20a. EXTERNAL CAUSE WAS | | 20b. TIME OF INJURY | | 20c. HOW INJURY OCCURRED | | 20d. HOW INJURY OCCURRED | | 20e. HOW INJURY OCCURRED | | 20f. HOW INJURY OCCURRED | | 20g. HOW INJURY OCCURRED | | 20h. HOW INJURY OCCURRED | | 20i. HOW INJURY OCCURRED | | 20j. HOW INJURY OCCURRED | |
| UNDERLYING | | HOUR A.M. MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | |
| CONTRIBUTING | | P.M. 19 | | 21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21b. LOCATION | | 21c. LOCATION | | 21d. LOCATION | | 21e. LOCATION | | 21f. LOCATION | | 21g. LOCATION | | 21h. LOCATION | |
| WHILE AT WORK | | 21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21b. LOCATION | | 21c. LOCATION | | 21d. LOCATION | | 21e. LOCATION | | 21f. LOCATION | | 21g. LOCATION | | 21h. LOCATION | | 21i. LOCATION | |
| NOT WHILE AT WORK | | 21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21b. LOCATION | | 21c. LOCATION | | 21d. LOCATION | | | | | | | | | | | |

MEDICAL CERTIFICATION

BP_____

DHMH - 17

(VR A15 ME (5))

DHMH - 17
/R A15 ME (5))

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053681 MAY 18

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director. Page 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CATHARINE GREENWELL PFAFF | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 12, 1987 | | | 2b. HOUR 4:10 a.m. | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR NOV. 16, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S 20650 MD | | | |
| 12. CITY OR TOWN OF DEATH LEONARDTOWN | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RT. #1 | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 15. KIND OF BUSINESS OR INDUSTRY | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY ST. MARY'S | | 13c. CITY OR TOWN LEONARDTOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS RT. #1, BOX 56B 20650 | |
| 17. FATHER'S NAME FIRST MIDDLE LAST JAMES J. GREENWELL | | 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAMIE COMBS | | 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | | |
| 20. SOCIAL SECURITY NO. 213-74-2225 | | 21. INFORMANT P.O. BOX 661 JOHN R. DRURY, LEONARDTOWN, MARYLAND 20650 | | | | | | | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of Colon c Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Actual fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 23. DATE OF OPERATION | | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 25. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 26. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 32. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 33. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 34. SIGNATURE <i>[Signature]</i> | | 35. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 36. DATE SIGNED 5-12-87 | | | | | |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT) V. SHAH, M.D. | | 38. ADDRESS SHANTI MEDICAL BLDG., LEONARDTOWN, MD. | | | | | | | |
| 39. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 40. DATE 5/14/87 | | 41. NAME OF CEMETERY OR CREMATORY OUR LADY'S | | 42. LOCATION MEDLEY'S NECK COUNTY STATE LEONARDTOWN, ST. MARY'S, MD. | | | |
| 43. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD. | | 44. ADDRESS | | 45. DATE REC'D. BY REGISTRAR MAY 15 1987 | | 46. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the

052681 MAY

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15341
REG. NO.

| | | | | | | | | |
|---|--|---|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY RUDOLPH PILKERTON | | | 2a. DATE OF DEATH MONTH DAY YEAR May 3, 1987 | | 2b. HOUR 9:20P M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 18, 1982 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 4 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD. | | |
| 10. CITY OR TOWN OF DEATH Leonardtwn | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | 13b. COUNTY St. Mary's | | 13c. CITY OR TOWN Leonardtwn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Rudolph Pilkerton | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Mae Adams | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS James R. Pilkerton same as 13e. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: (c) Congenital heart DE. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes hours 4 1/2 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Pulmonary Hypertension | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the undersigned) attended the deceased from 5-23-87 to 5-3-87 , that (I) (last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE J. Patrick Jarboe, M.D. | | 22c. ADDRESS Leonardtwn, Md. 20650 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Patrick Jarboe, M.D. | | 22e. ADDRESS Leonardtwn, Md. 20650 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-6-87 | | 23c. NAME OF CEMETERY OR CREMATORY Our Lady's | | 23d. LOCATION CITY OR TOWN COUNTY STATE Valley Lee, St. Mary's, Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley, Leonardtwn, Md. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 6 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers | | |

BP

054082 MAY 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5342

| | | | | | |
|--|-------------------------|---|---|---|---------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN FRANCIS REED | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 14 19 87 | | 2b. HOUR M 11:20 P |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 11, 1954 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 33 YRS. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 14 19 87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County | | 10. CITY OR TOWN OF DEATH Patuxent River | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Naval Air Station Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY Restaurant | | 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | |
| 13b. COUNTY St. Mary's | | 13c. CITY OR TOWN Lexington Park | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 16 Renell Dr./20653 | | 14. FATHER'S NAME FIRST MIDDLE LAST Carroll Elmer Reed | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian L. Butler | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. Helen Cole, P.O. 547, Hughesville, Md. | | 17. INFORMANT ADDRESS Helen Cole, P.O. 547, Hughesville, Md. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Stab wounds of chest and neck

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR **10:30** MONTH **5** DAY **14** YEAR **1987**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

Subject was stabbed.

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

yard

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE
4 Tanner Ave., Lexington Pk., St. Mary's, MD22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐.ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. **Deputy Chief** MEDICAL EXAMINERDATE SIGNED **5-15-87**EXAMINER'S NAME
(TYPE OR PRINT)**Ann M. Dixon, M.D.**ADDRESS **111 Penn St., Balto., MD 21201**23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)**Burial**

23b. DATE

5-18-87

23c. NAME OF CEMETERY OR CREMATORY

Charles Memorial23d. LOCATION
(CITY OR TOWN)**Leonardtwn, St. Mary's, Md.**24. FUNERAL DIRECTOR
NAME**W. Clarke Mattingley, Leonardtown, Md.**

ADDRESS

25a. DATE REC'D. BY REGISTRAR

MAY 19 1987

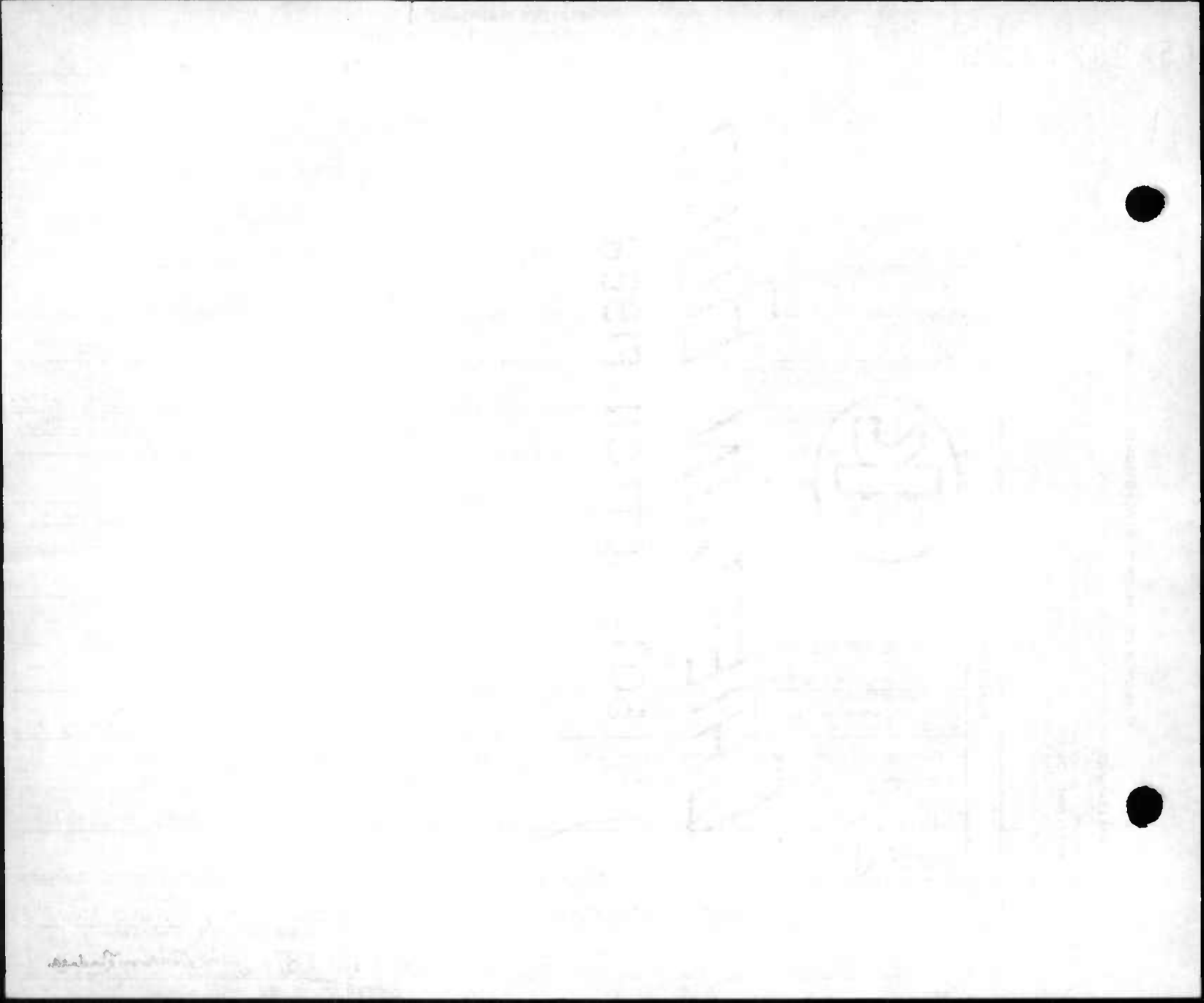
25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

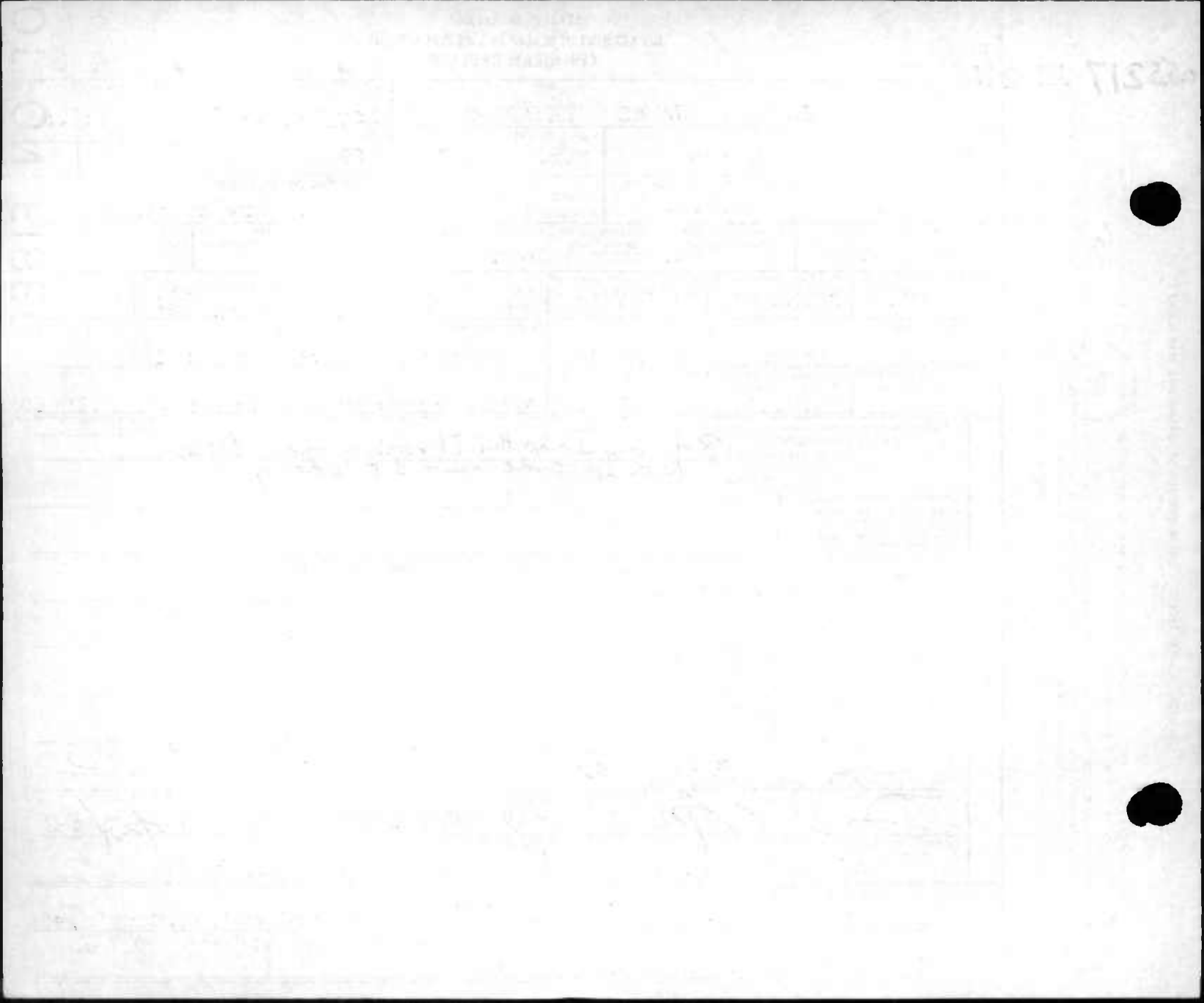
07/84
25MBP
DHMH - 17
(VR A15 ME (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15343

| | | | | | |
|---|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) WILBUR JAMES REYNOLDS | | 2a. DATE OF DEATH MONTH DAY YEAR May 22, 1987 | | 2b. HOUR 7:00 AM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 1, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD. | |
| 10. CITY OR TOWN OF DEATH Leonardtwn | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's County | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | 13b. COUNTY St. Mary's | 13c. CITY OR TOWN Medley's Neck | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Riley Roger Reynolds | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Virginia Fulks | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. W.W.11 577-05-9071 | | 17. INFORMANT ADDRESS Olive Derringer, Leonardtown, Md. 20650 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Refractory Idiopathic Thrombocytopenic Purpura</u> DUE TO, OR AS A CONSEQUENCE OF <u>with probable acute G.I. bleeding</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> 19 <u>87</u> , to <u>5/22</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/22</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>David Allen</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>5/23/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Allen, M.D. | | 22e. ADDRESS Leonardtwn, Md. 20650 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 5-25-87 | 23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn, St. Mary's, Md. | |
| 24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md. | | 25a. DATE REC'D. BY REGISTRAR <u>JUN 1 1987</u> 25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u> | | | |



053406 MAY 1

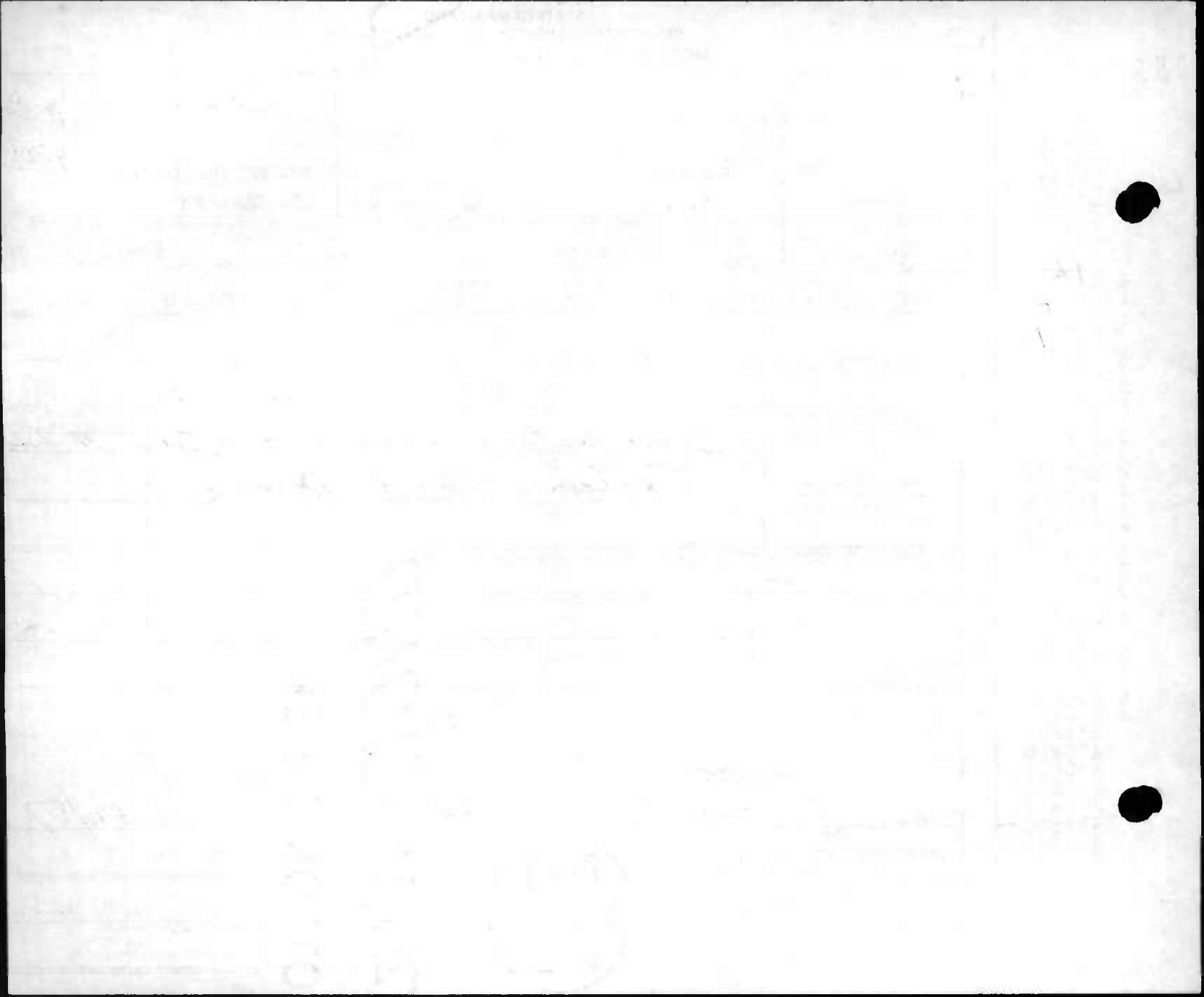
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (1))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 5344 | | | |
|--|--|------------------------|--|---|--|--|--|---|--|--|--|------------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2a DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input checked="" type="checkbox"/> MAY 9, 1987 | | 2b HOUR 11:00 PM | |
| 1. DECEASED NAME FIRST MIDDLE LAST ABNER SEYMOUR RICHMAN | | | | | | | | | | 2c DATE PRONOUNCED DEAD MAY 10, 1987 | | 2d HOUR 4:30 PM | |
| 3. SEX MALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 23, 1916 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD. | | | |
| 10. CITY OR TOWN OF DEATH LEXINGTON PARK | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 114 HARBOR LANE | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER | | | 12b KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a STATE MARYLAND | | 13b. COUNTY ST. MARY'S | | 13c. CITY OR TOWN LEXINGTON PK. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 114 HARBOR LANE | | 20653 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAM RICHMAN | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE MAK | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. 1946-1966 | | 17. INFORMANT BOX 3109 ROSALIE DOOLEY, A.P.O., N.Y. 09009 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Death - Prob Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <u>Ischemic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>David C. Allen</u> | | | | TITLE (SPECIFY) M.D. <u>Acting Dep</u> | | | | DATE SIGNED <u>5/11/87</u> | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) DAVID C. ALLEN, M.D. | | | | ADDRESS LEONARDTOWN, MARYLAND 20650 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 5/13/87 | | 23c. NAME OF CEMETERY OR CREMATORY MORAVIAN | | 23d. LOCATION CITY OR TOWN COUNTY STATE STATEN ISLAND, RICHMOND, N.Y. | | | | | |
| 24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD. | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR MAY 13 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Tindon-Rubels</u> | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

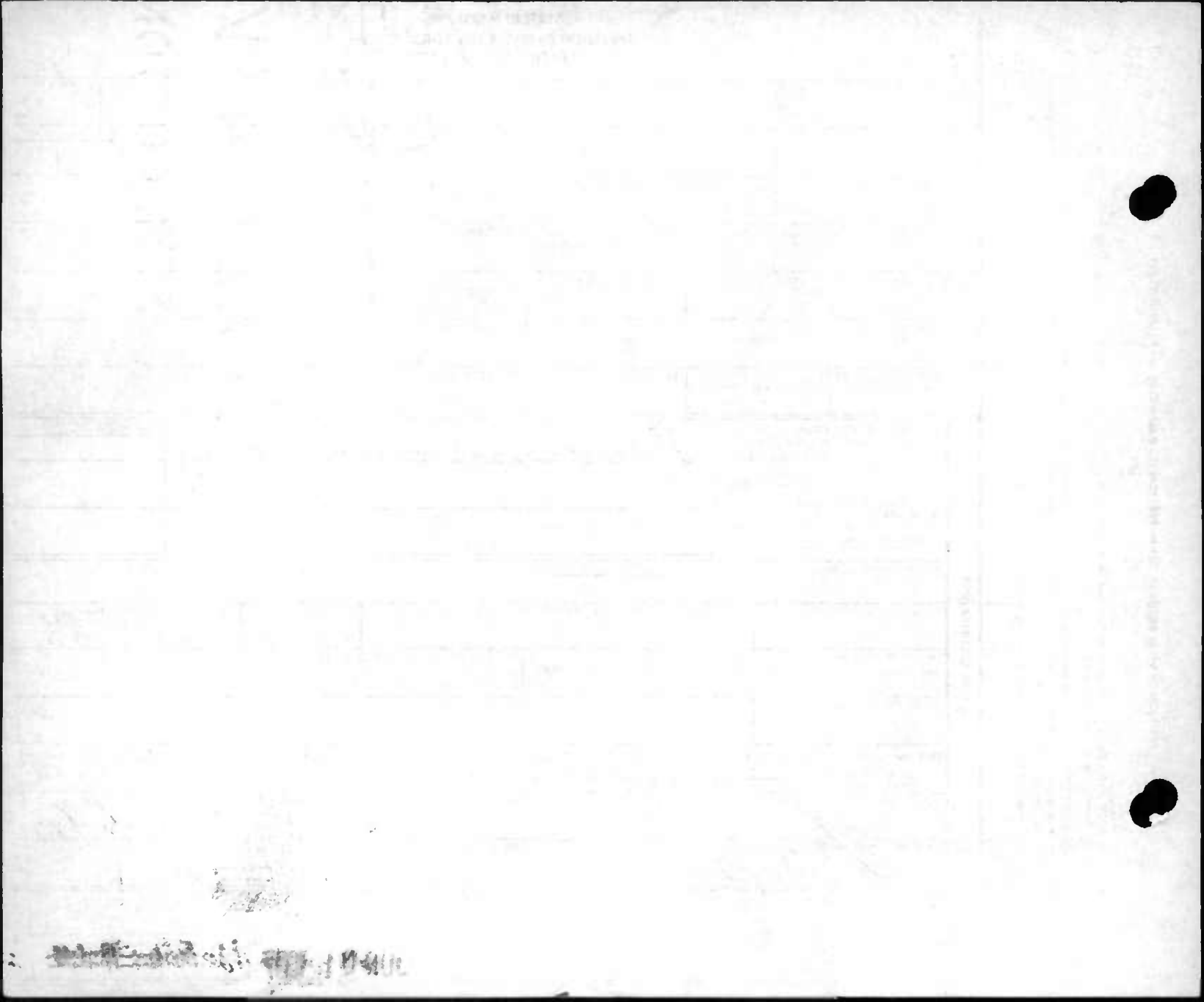
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15345

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALLACE AUGUSTA RIDGELL | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 26, 1987 | | 2b. HOUR 8:45p M |
| 3. SEX MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR OCT. 25, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD. | |
| 10. CITY OR TOWN OF DEATH LEONARDTOWN | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MARYLAND | | 13b. COUNTY ST. MARY'S | 13c. CITY OR TOWN RIDGE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM RIDGELL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCY RIDGELL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-26-3588 | | 17. INFORMANT GENERAL DELIVERY EDWARD RIDGELL, MORGANZA, MARYLAND 20660 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mitral Aortic Carcinoma of Lung</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-1-</u> 19 <u>85</u> to <u>5-26</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-26</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>James C. Boyd</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES C. BOYD, M.D. | | 22e. ADDRESS 17 JEFFERSON ST., LEONARDTOWN, MD. 20650 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5/29/87 | | 23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS | |
| 23d. LOCATION (CITY OR TOWN) COUNTY STATE RIDGE, ST. MARY'S, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR JUN 01 1987 | | | |
| 24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD. | | 25. REGISTRAR'S SIGNATURE <i>Edward N. Brinsfield, Jr.</i> | | | |



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC NO 5346

| | | | | | | | | | | | | | | | |
|---|--|------------------|--|---|--|--|--|--|--|--------------------------|--|---|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED MAY 1, 1987 | | 2b. DATE MONTH DAY YEAR | | 2c. HOUR 10:06 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 27 1910 | | 6. AGE (IN YEARS) LAST BIRTHDAY 76 RS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. | | 9. DATE Pronounced Dead | | 10. DATE 5 1 1987 | |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 14. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD. | | | |
| 15. CITY OR TOWN OF DEATH Leonardtown | | | | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital | | | | 17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | | | 18. KIND OF BUSINESS OR INDUSTRY AT HOME | | | |
| 19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 19a. STATE Md. | | | | 19b. COUNTY ST. MARY'S | | | | 19c. CITY OR TOWN MECHANICSVILLE | | | | 19d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20. FATHER'S NAME FIRST MIDDLE LAST NORMAN A. COOKE | | | | 21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE E. COOKE | | | | 22. STREET ADDRESS 3459 CHANEYVILLE RD OWINGS, Md. 20736 | | | | 23. ADDRESS 3459 CHANEYVILLE RD OWINGS, Md. 20736 | | | |
| 24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 25. SOCIAL SECURITY NO. 579-30-5417 | | | | 26. INFORMANT HOLLY A. LUKAT | | | | 27. ADDRESS 3459 CHANEYVILLE RD OWINGS, Md. 20736 | | | |
| 28. CAUSE OF DEATH (Enter only one cause per line form (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sec. | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 29a. DATE OF OPERATION | | | | 29b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 29c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 30a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 30b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 30c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 31a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 31b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 31c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 32a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| 33. ACTUAL SIGNATURE Wm D Boyd MD | | | | 33b. TITLE (SPECIFY) Dpt | | | | 33c. MEDICAL EXAMINER Leonard Town, Md. | | | | 33d. DATE SIGNED 5/2/87 | | | |
| 34. EXAMINER'S NAME (TYPE OR PRINT) | | | | 34b. ADDRESS | | | | 34c. STATE Md. | | | | | | | |
| 35a. BURIAL (SPECIFY) | | | | 35b. DATE 5-5-1987 | | | | 35c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | | | | 35d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, P.G.C. Md. | | | |
| 36. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. | | | | 36b. ADDRESS RIVERDALE, Md. 20737 | | | | 36c. DATE REC'D. BY REGISTRAR MAY 11 1987 | | | | 36d. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

[illegible]

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(VR A15 ME (5))
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054518 MAY 26 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. The medical examiner must be notified at once. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

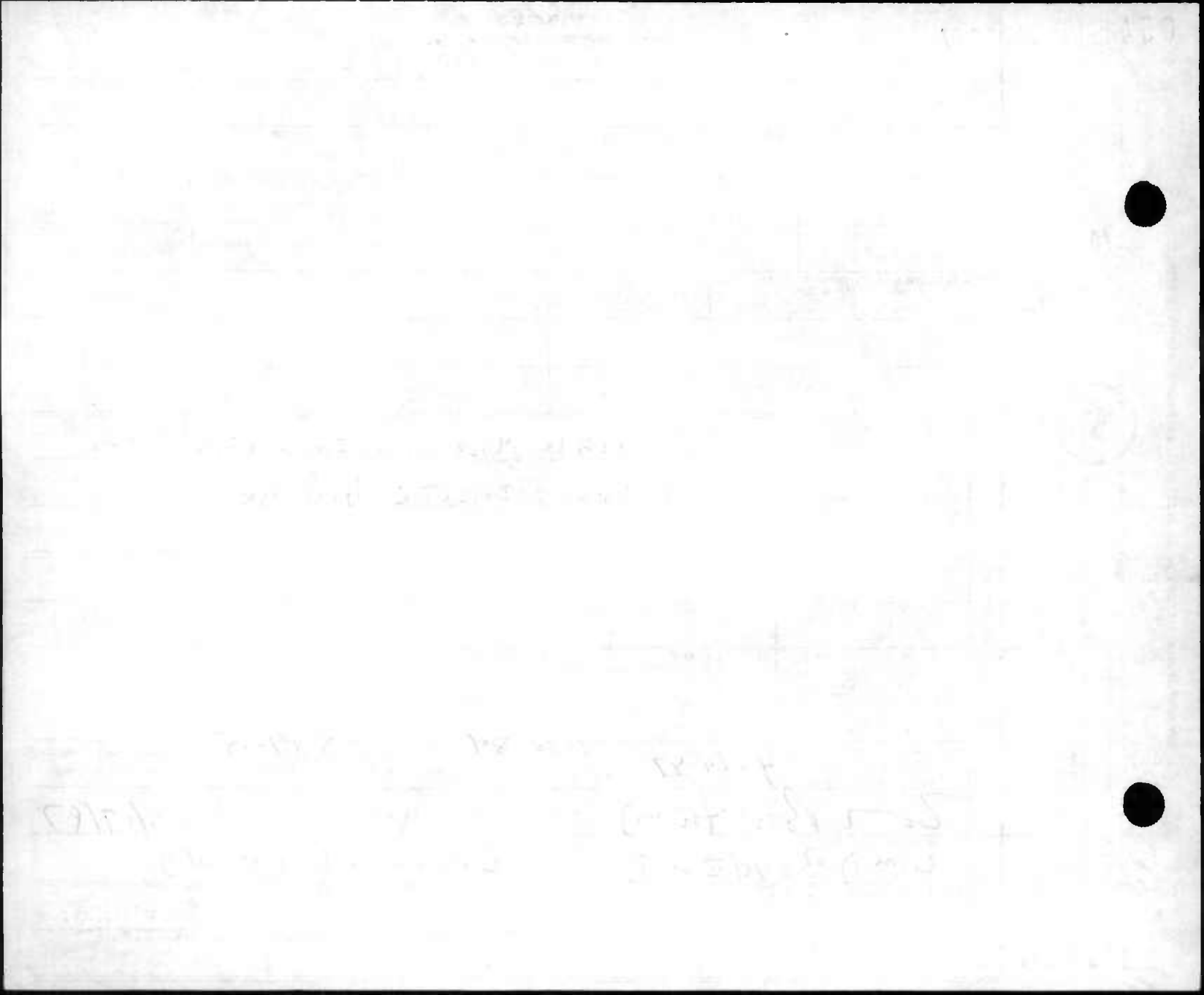
87 REG. NO. 15347

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLA MARIE RUSSELL | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 19, 1987 | | 2b. HOUR M |
| 3 SEX Female | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 20, 1900 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 86 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD | |
| 10. CITY OR TOWN OF DEATH Colton's Point | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Md. | 13b. COUNTY St. Mary's | 13c. CITY OR TOWN Coltons Point | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS General Deliver/20626 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Turner | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Phillips | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-74-1134 | | 17. INFORMANT ADDRESS Edward P. Russell, same as 13e. | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Disease DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sec. |
|---|--|---|

| | | | | | |
|--|--|--|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-30-84 19 to 5-19-85 19, that (I) (we) last saw the deceased alive on 4-14-87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Wm D Boyd II MD | | | | 22c. DATE SIGNED 5/19/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm D Boyd II MD | | | | 22e. ADDRESS Leonardtown, MD. | |

| | | | |
|--|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 5-22-87 | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Bushwood, St. Mary's, Md. |
| 24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley, Leonardtown, Md. | | | 25a. DATE REC'D. BY REGISTRAR MAY 25 1987 |
| | | | 25b. REGISTRAR'S SIGNATURE |



1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

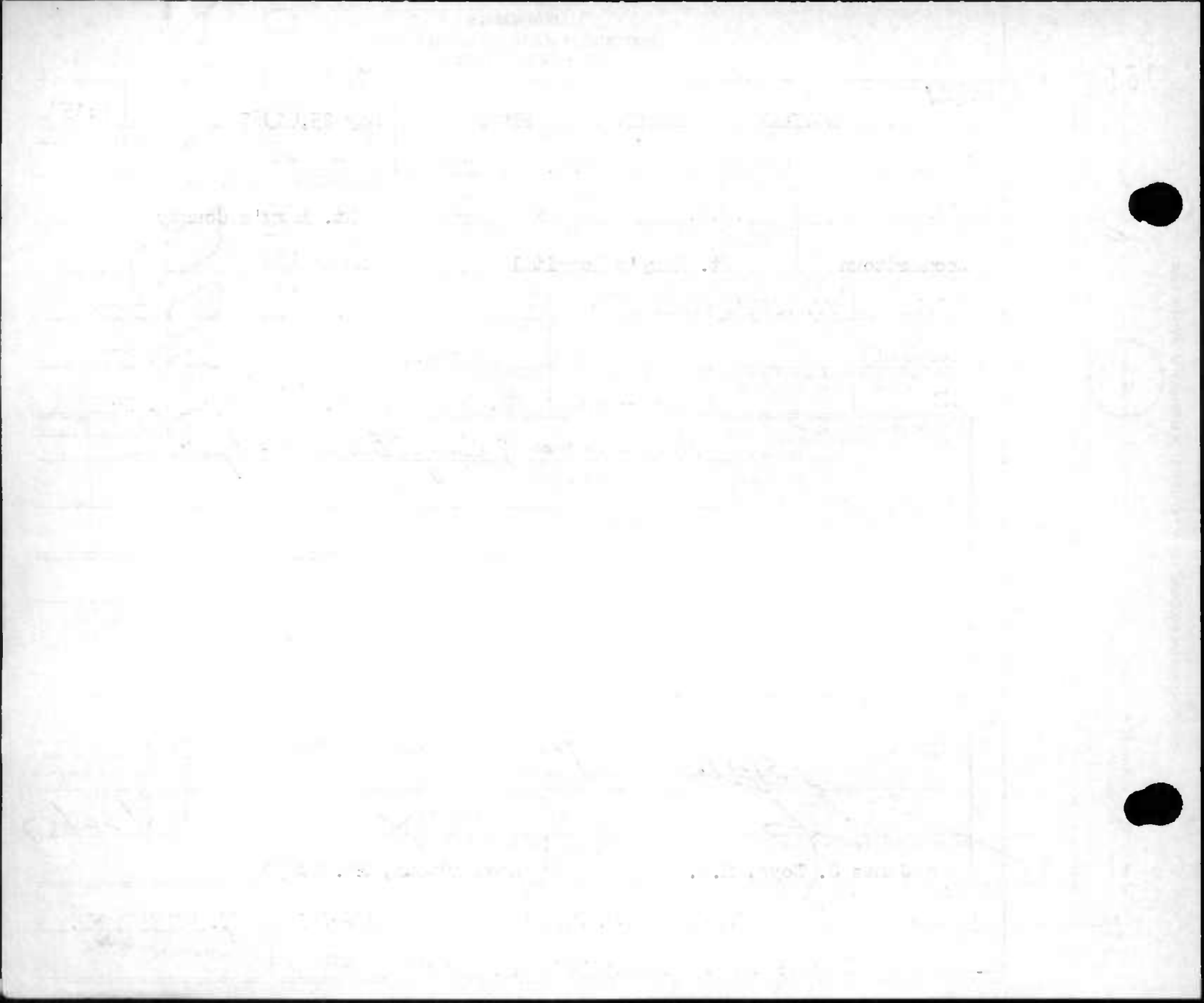
87 REG. NO. 5348

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|---|--|---|--|---|-------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCILLE SOPHIA STONE | | | 2a. DATE OF DEATH MONTH DAY YEAR May 25, 1987 | | 2b. HOUR 4:15^A | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR FEB. 6, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD. | |
| 10. CITY OR TOWN OF DEATH Leonardtown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY ST. MARY'S | | 13c. CITY OR TOWN HOLLYWOOD | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN GOLDSBOROUGH | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADRIANA NORRIS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 217-34-0439 | |
| 17. INFORMANT ADDRESS RT. #1, BOX 27 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia; Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | 19. MRS. AGNES G. GUY, HOLLYWOOD, MD. 20636 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/25 , 19 80 , to 5/25 , 19 87 , that (I) (we) last saw the deceased alive on 5/22/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign this entry after death. | | | | | | | |
| 22b. SIGNATURE James C. Boyd, M.D. | | DEGREE | | 22c. DATE SIGNED 5/26/87 | | 22d. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Boyd, M.D. | | 22f. ADDRESS Leonardtown, Md. 20650 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | |
| 23b. DATE 5/27/87 | | 23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS | | 23d. LOCATION CITY OR TOWN COUNTY STATE HOLLYWOOD, ST. MARY'S, MD. | | | |
| 24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD. | | 25a. DATE REC'D. BY REGISTRAR JUN 1 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia D. ...</i> | | | |

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked under 18, a traumatic injury, or other traumatic event, the medical examiner must be notified.

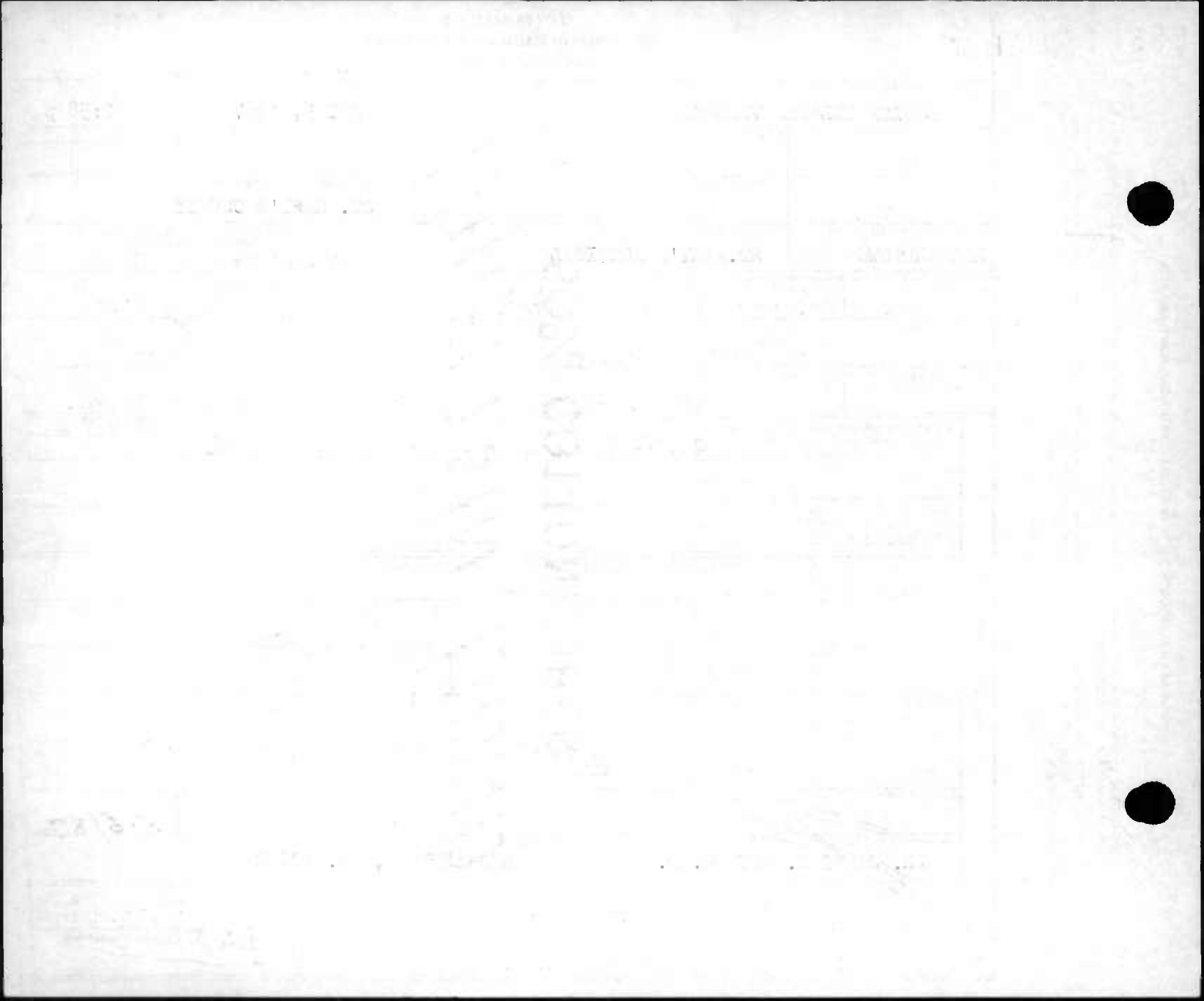


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

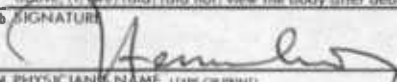
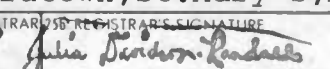
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LOUISE CELESTE VENDRONE | | | | | | 2a. DATE OF DEATH MAY 5, 1987 | | 2b. HOUR 2:58 p.m. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 25, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH LEONARDTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife. | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Md. | | | | 13b. COUNTY St. Mary's | | 13c. CITY OR TOWN Lexington Park | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Raymond Vaden | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna V. Ford | | 13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 377, /20653 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES No | | 16b. SOCIAL SECURITY NO. 228-03-2228 | | 17. INFORMANT ADDRESS Blanche Moneymaker, Park Hall, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Metastatic Lung Cancer</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/5</u> , 19 <u>87</u> , to <u>5/5</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>DR. JAMES C. BOYD M. D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5/6/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JAMES C. BOYD M. D. | | | | 22e. ADDRESS LEONARDTOWN, MD. 20650 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-8-87 | | 23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lexington Park, St. Marys, Md. | | | |
| 24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonartown, Md. | | | | 25a. DATE REC'D BY REGISTRAR MAY 8 1987 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 60M 7/84
(VRA 15. 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 15350

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN PLOWDEN WATHEN SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR May 13, 1987 | | 2b. HOUR 12:20 PM | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 2, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Leonardtwn | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) State Highway Adm. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | 13b. COUNTY St. Mary's | | 13c. CITY OR TOWN Leonardtwn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Rt. 2, Box 65-B, / 20650 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ford William Wathen | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Harden | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1941-44 | | 17. INFORMANT Mary Alwilda Wathen | | | | ADDRESS same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Electro mechanical dissociation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute myocardial infarction + shock</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE  | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/14/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Fenwick, M.D. | | | | | | 22e. ADDRESS Leonardtwn, MD 20650 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5-16-87 | | 23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gardens | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn, St. Mary's, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley, Leonardtown, Md. | | | | | | 25. DATE REC'D. BY REGISTRAR / REGISTRAR'S SIGNATURE MAY 19 1987  | | | | | |

MEDICAL CERTIFICATION

BP

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **5351**

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | |
|--|---------|--|-------------------|---|------------------|---|--|-----------------------------------|-----|------|----------|
| DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH ESTIMATED | | MONTH | DAY | YEAR | 2b. HOUR |
| MARY AGNES YORKSHIRE | | | | | | MAY 27, 87 | | | | | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | MONTH | DAY | YEAR | 2d. HOUR |
| Female | Black | July 22, 1922 | 64 | MONTHS | DAYS | 19 | | | | | M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | U.S.A. | | | | St. Mary's | | MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Leonardtawn | | St. Mary's Hospital | | | | Cook | | Restaraunt | | | |
| 13a. STATE | | | | | | | | | | | |
| Md. | | | | | | | | | | | |
| 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| St. Mary's | | Mechanicsville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | Rt. 4, Box 282 | | 20659 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| Marie | | | | Medley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | 220-16-4774 | | Peggy Yorkshire, same as 13e | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

Acute Myocardial Infarction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? |
| | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquest ☒ and in my opinion death resulted from: Natural cause ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE *[Signature]* TITLE (SPECIFY) M.D. MEDICAL EXAMINER DATE SIGNED *5/29/87*
EXAMINER'S NAME (TYPE OR PRINT) Dr. James C. Boyd, M.D. ADDRESS Leonardtown, Md.

| | | | |
|---|-----------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | 6-1-87 | Charles Memorial Gardens | Leonardtawn, St. Mary's, Md |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE FILED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | |
| W. Clarke Mattingley, Leonardtown, Md. | | JUN 3 1987 <i>Julia Sanders-Randall</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PK 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

